

UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD

CORE BOARD MEETING

Arlington, Virginia

Tuesday, November 2, 2010

1 PARTICIPANTS:

2 Core Board Members:

3 WAYNE LEDNAR, M.D., Ph.D.

4 GREGORY POLAND, M.D.

5 CHRISTINE BADER

6 COLONEL (Ret.) ROBERT CERTAIN

7 JOHN CLEMENTS, Ph.D.

8 NANCY W. DICKEY, M.D.

9 FRANCIS A. ENNIS, M.D.

10 WILLIAM HALPERIN, M.D.

11 EDWARD KAPLAN, M.D.

12 JAMES LOCKEY, M.D.

13 RUSSELL LUEPKER, M.D.

14 THOMAS J. MASON, Ph.D.

15 GENERAL (Ret.) RICHARD MYERS

16 DENNIS O'LEARY, M.D.

17 JOSEPH E. PARISI, M.D.

18 MICHAEL PARKINSON, M.D.

19 ADIL E. SHAMOO, Ph.D.

20 JOSEPH SILVA, M.D.

21 DAVID WALKER, M.D.

22 HONORABLE TOGO WEST

1 PARTICIPANTS (CONT'D):

2 Task Force Members:

3 BRIGADIER GENERAL PHILIP VOLPE

4 COLONEL JOANNE McPHERSON

5 FLORABEL MULLICK, M.D., Sc.D.

6 RIDGELY RABOLD

7 KENNETH W. KIZER, M.D.

8 CHARLES FOGELMAN, Ph.D.

9 THOMAS W. UHDE, M.D.

10 FRANK K. BUTLER, JR., M.D.

11 Service Liaison Officers:

12 GROUP CAPTAIN ALAN COWAN

13 LIEUTENANT COLONEL PHILIP GOULD

14 COLONEL WAYNE HACHEY

15 COLONEL MICHAEL KRUKAR

16 COLONEL ROBERT MOTT

17 CAPTAIN NEAL NAITO

18 COMMANDER ERICA SCHWARTZ

19 Flag Staff Officers:

20 VICE ADMIRAL JOHN MATECZUN

21 MAJOR GENERAL DOUGLAS J. ROBB

22 BRIGADIER GENERAL PHILIP VOLPE

1 PARTICIPANTS (CONT'D):

2 CAPTAIN NOE MUNIZ

3 ASD Staff:

4 COLONEL NANCY DEZELL

5 ALLEN MIDDLETON

6 LIEUTENANT MAJOR TONJA BROWN

7 General Mailing List:

8 LIEUTENANT COLONEL(P) STEVEN CERSOVSKY

9 COLONEL RENATA ENGLER

10 COLONEL JAMIE GRIMES

11 DR. GEORGE LUDWIG

12 CAPTAIN SHARON LUDWIG

13 DR. PERRY MALCOLM

14 DR. WILLIAM UMHAU

15 Additional Invitees:

16 JOHN ALLEN

17 A.J. AWAN

18 LAKIA BROCKENBERRY

19 CAPTAIN JOYCE CANTRELL

20 DR. LIMONE COLLINS

21 DENISE DAILY

22 STEVEN EBERLY

1 PARTICIPANTS (CONT'D):

2 DR. FIRPO-BETANCOURT

3 DEBORAH FUNK

4 ELDESIA GRANGER

5 JEFF HACKMAN

6 JOHN HACKMAN

7 DR. JOAN HALL

8 RYAN HEIST

9 COLONEL DONALD JENKINS

10 JOSEPH JORDAN

11 DR. STEVEN KAMINSKY

12 PHILIP KARASH

13 JOHN LUDWIG

14 GENE MILLER

15 LARRY NISENOFF

16 PAUL REPACI

17 ALMA RICO

18 STEPHEN SCANGO

19 COMMANDER CYNTHIA SIKORSKI

20 PORTIA SULLIVAN

21 PAUL WILSON

22

1 PARTICIPANTS (CONT'D):

2 DHB Staff:

3 CHRISTINE E. BADER
Director and Designated Federal Official

4 COLONEL JOANNE McPHERSON
5 Executive Secretary

6 CCSI Contractors:

7 MARIANNE COATES

8 JEN KLEVENOW

9 LISA JARRETT

10 OLIVERA JOVANIC

11 ELIZABETH MARTIN

12 HILLARY PEABODY

13 BRITTNEY SCHNESSLER

14 KAREN TRIPLETT

15 Presenters:

16 COLONEL THOMAS BAKER

17 WILLIAM HALPERIN, M.D.

18 DR. JAMES KELLY

19 CAPTAIN JEFF TIMBY

20 Court Reporter:

21 CHRISTINE ALLEN

22 * * * * *

1 P R O C E E D I N G S

2 (8:59 a.m.)

3 DR. LEDNAR: Good morning everyone. I'd
4 like to welcome everyone to day two of the Defense
5 Health Board. We have several important topics on
6 our agenda today. But before we begin we'd ask if
7 General Robb would share with us an article that
8 has appeared in today's local newspaper that would
9 be of interest to the Board. General Robb?

10 MAJOR GENERAL ROBB: First off, I'd like
11 to thank everybody on behalf of the Chairman for
12 what you all do each and every day. I think it
13 was rather timely that there was an article in
14 today's Washington Post that was spot on about
15 what we were talking about yesterday. In case you
16 haven't seen it, it's called "The Well-Armed
17 Medic" and was talking about what they carry in
18 their backpack, to talk specifically about Hextend
19 in here and the discussions that we had yesterday.
20 If you read the article which is very timely,
21 you'd think that you were reading about the
22 briefing we got yesterday about the pros and cons

1 of whole blood and component therapy and why we
2 use Hextend or that type of material because it's
3 about weight and cube. Sixty pounds these young
4 medics have on their backs. Sixty pounds of
5 life-saving equipment. When we're debating here
6 the efficacy of a liter of something versus a half
7 a liter of something, it makes a difference. So
8 these are very, very important and very, very
9 timely discussions that we are having here.

10 Again, on behalf of the chairman and the
11 entire Department of Defense, thank you all for
12 what you do each and every day to make the quality
13 and the quantity of life for our soldiers,
14 sailors, airmen, Marines, coalition forces and
15 civilians as we go out and support the war fight.

16 The second thing I'd like to share with
17 you is that I had the opportunity last week to
18 view the premier of an HBO special called
19 War-Torn. It's done by the same group that did
20 Band of Brothers and Baghdad E.R. What it talks
21 about is posttraumatic stress or posttraumatic
22 stress disorder, in other words, when it makes

1 your life dysfunctional. It's fascinating and it
2 will premier on November 11, Veterans Day. I
3 share with you all that I believe it's a must-see
4 for the men and women I believe on this Board
5 because it captures the essence of what we're
6 trying to put our arms around with this entity of
7 psychological health and posttraumatic stress.

8 What it does, it does a chronology from
9 the Civil War up to the current conflict, the
10 Civil War, then it goes to World War I, World War
11 II, Vietnam and the current conflict. It tells
12 the story through letters in the Civil War and
13 then footage and testimonials in World War I,
14 footage and testimonials in World War II, but in
15 World War II which is really the oldest surviving
16 group of veterans that we have, it's a group of
17 them in a room talking about how they just weren't
18 quite right when they came back and what they had
19 to put up with and what their families and the
20 burden that societies has with how do we deal with
21 these men and women who have this posttraumatic
22 stress and it really captures it. Then of course

1 it talks about the current conflict. In fact, we
2 had in our audience two of the families of folks
3 who had committed suicide and they tell the story
4 as you'll see in this documentary about what their
5 sons and their daughters went through when they
6 came back from this conflict.

7 Again it's well worth seeing. It
8 captures the essence of posttraumatic stress, but
9 really it captures what it means to society and
10 then the families and you'll see there's a really
11 special part at the end about a family that's
12 sticking with their soldier and how they get
13 through daily life. I think it will if nothing
14 else energize us on what our end state is and what
15 your target is and where we need to go to support
16 these men and women.

17 Again, on behalf of the chairman -- I
18 have to leave this morning. I'm actually moving
19 today. But again, on behalf of the chairman and
20 our entire staff, thank you all for what you do
21 each and every day. I don't know if we say that
22 enough. We probably don't. Again, good luck for

1 the rest of the conference. Thank you.

2 DR. BUTLER: I have to add one quick
3 postscript to that. FYI, the first person to
4 start to push the modern generation of lifesaving
5 things out onto the battlefield specifically
6 tourniquets and hemostatic agents was the CENTCOM
7 Surgeon in 2005, Colonel Doug Robb.

8 DR. LEDNAR: Thank you, General Robb for
9 telling us about the article today in The
10 Washington Post and the upcoming documentary. We
11 will get the reminder out to everyone in case you
12 can't remember next week when it is November 11.

13 I'd ask at this time Ms. Bader as our
14 designated federal officer if she would please
15 call this meeting of the Defense Health Board to
16 order. Ms. Bader?

17 MS. BADER: Thank you. As the
18 designated federal officer for the Defense Health
19 Board, a federal advisory committee and a
20 continuing independent scientific advisory body to
21 the Secretary of Defense via the Assistant
22 Secretary of Defense for Health Affairs and the

1 surgeons general of the military departments, I
2 hereby call this meeting of the Defense Health
3 Board to order.

4 DR. LEDNAR: Thank you, Ms. Bader. In
5 keeping with our practice of the Defense Health
6 Board, we'd like to begin our meeting by please
7 standing and let's spend a moment of silence in
8 honor of the men and women who serve our country
9 and keep us free.

10 (Moment of silence)

11 DR. LEDNAR: Thank you. Please be
12 seated. This is an open session of the Defense
13 Health Board. What we would like to do is to
14 begin by being sure that everyone has an idea of
15 who's here, so we'd like to please start with
16 introductions and if you'd give your name and your
17 affiliation. If we can start, we'll start in the
18 opposite direction from yesterday. Mr. Bader, if
19 you would begin and we'll go around the table and
20 then we'll ask our guests to introduce themselves.
21 Ms. Bader?

22 MS. BADER: Good morning. Christine

1 Bader, director, Defense Health Board.

2 VICE ADMIRAL MATECZUN: Vice Admiral
3 John Mateczun, commander, Joint Task Force,
4 National Capital Region.

5 FATHER CERTAIN: Robert Certain, member
6 of the core board and retired Air Force chaplain.

7 DR. LOCKEY: Jim Lockey, occupational
8 and pulmonary physician at the University of
9 Cincinnati and member of the Board.

10 DR. CLEMENTS: John Clements, chair of
11 Microbiology and Immunology, director of the
12 Tulane University Center for Infectious Diseases
13 and member of the core board.

14 DR. PARKINSON: Mike Parkinson, past
15 president of the American College of Preventive
16 Medicine working with health care organizations
17 and employers today about performance.

18 DR. SHAMOO: Adil Shamoo, University of
19 Maryland School of Medicine and member of the
20 Board. There is no such thing as core board.

21 DR. KAPLAN: Ed Kaplan, professor,
22 pediatrics at the University of Minnesota Medical

1 School and member of the Board.

2 DR. BUTLER: Frank Butler, chair of the
3 Committee on Tactical Combat Casualty Care.

4 COLONEL MOTT: Bob Mott. I'm with the
5 Army Surgeon General's Office and the Army
6 liaison.

7 COMMANDER SCHWARTZ: Erica Schwartz,
8 Coast Guard liaison.

9 CAPTAIN NAITO: Neal Naito, Navy
10 liaison.

11 LIEUTENANT COLONEL GOULD: Phil Gould,
12 Air Force liaison.

13 COLONEL HACHEY: Wayne Hachey, ODS
14 Health Affairs liaison.

15 COMMANDER PADGETT: Bill Padgett, Marine
16 Corps liaison.

17 COMMANDER SLAUNWHITE: Commander Cathy
18 Slaunwhite, Canadian Forces medical officer in
19 liaison at the embassy in Washington, D.C.

20 GROUP CAPTAIN COWAN: Alan Cowen,
21 British liaison officer to the Department of
22 Defense.

1 DR. MULLICK: Florabel Mullick,
2 director, AFIB, soon to be nonexistent, and also
3 executive secretary of the Subcommittee Laboratory
4 and Pathology for the Defense Health Board.

5 DR. KIZER: Ken Kizer, chairman,
6 Medsphere Systems.

7 DR. O'LEARY: Dennis O'Leary, President
8 Emeritus of the Joint Commission and Board member.

9 DR. MASON: I'm Tom Mason, professor of
10 environmental and occupational health at the
11 University of South Florida and a member of the
12 Board.

13 DR. DICKEY: Nancy Dickey, president of
14 the Texas A&M Health Science Center and a member
15 of the Board.

16 DR. WALKER: David Walker, professor and
17 chair of pathology at the University of Texas
18 Medical Branch at Galveston and member of the
19 Board.

20 DR. SILVA: Joe Silva, professor of
21 internal medicine and infectious diseases,
22 University of California- Davis, Dean Emeritus,

1 member of the Board.

2 DR. PARISI: I'm Joseph Parisi,
3 professor of pathology at the Mayo Clinic College
4 of Medicine in Rochester, Minnesota, also chair of
5 the Subcommittee on Pathology and Laboratory
6 Services for the Defense Health Board and a member
7 of the Board.

8 DR. ENNIS: I'm Frank Ennis, professor
9 of medicine, Molecular Genetics and Microbiology
10 at the University of Massachusetts Medical School
11 and a member of the Board.

12 MAJOR GENERAL ROBB: Dr. Doug Robb. I'm
13 Joint Staff surgeon and a member of the Pentagon.

14 GENERAL MYERS: Dick Myers, retired
15 military and member of the Board.

16 DR. POLAND: Greg Poland, professor of
17 medicine and infectious diseases at the Mayo
18 Clinic, Rochester, Minnesota and one of the
19 co-VPs.

20 DR. LEDNAR: Wayne Lednar, global chief
21 medical officer of the DuPont Company and along
22 with Dr. Poland co-vice president of the Defense

1 Health Board.

2 MS. KLEVENOW: Jen Klevenow, DHB support
3 staff.

4 DR. LUDWIG: I'm George Ludwig. I'm the
5 deputy principal assistant for research and
6 technology at the Army Medical Research and
7 Materiel Command.

8 COLONEL DINIEGA: Ben Diniega, Health
9 Affairs.

10 COLONEL BAKER: Colonel Tom Baker, I'm
11 the interim director of the Joint Pathology
12 Center.

13 COLONEL WARDELL: Scott Wardell,
14 executive director, Administrative Operations JTF
15 CapMed.

16 DR. ERDTMANN: Rick Erdtmann, staff
17 director, Institute of Medicine, ex officio member
18 of the Board, former Army Medical Corps Officer.

19 COMMANDER SIKORSKY: Good morning.
20 Cindy Sikorsky, preventive medicine resident,
21 Uniformed Services University.

22 MR. HAILE: Jason Haile with Scitor

1 Corporation.

2 DR. BARTON: Joel Barton, pathologist
3 and deputy chairman of the Urinary Department
4 AFIP.

5 DR. SESTERHENN: Isabel Sesterhenn,
6 Chairman, Urinary Department at the AFIP and
7 future member of the JPC.

8 MR. APACHI: Pomer Apachi, Army Surgeon
9 General's Office.

10 MR. MILLER: Good morning. I'm Gene
11 Miller and I'm with Batel.

12 MS. COATES: Marianne Coates,
13 communications advisor to the Defense Health
14 Board, and one postscript if I can. The article
15 by David Brown is one of several. David Brown is
16 a physician with The Washington Post. Frank
17 Butler has given him an education before he
18 embedded for 1 month with the troops over in
19 Afghanistan and the articles are continuing to
20 come out. I think they're really good articles.
21 Thank you for bringing it up today.

22 LIEUTENANT COLONEL FAGAN: Nancy Fagan

1 from Health Affairs.

2 DR. GRANGER: Eldesia Granger, resident,
3 internal medicine, pediatrics, University of North
4 Carolina-Chapel Hill.

5 DR. UMHAU: I'm Dr. Bill Umhau, a family
6 medicine doctor, Occupational Health Environmental
7 Safety Services at NSA Fort Meade.

8 DR. CRON: I'm Kevin Cron. I'm a
9 preventive medicine resident.

10 MR. PERRY: Michael Perry, American
11 Registry of Pathology.

12 MR. RAYBOLD: Ridge Raybold, program
13 manager, Office of the Director, Armed Forces
14 Institute of Pathology.

15 MAJOR LEE: I'm Major Roger Lee from
16 Joint Staff at the Pentagon with the Joint Staff
17 Surgeon and the J-4 Health Service Support
18 Division.

19 MS. JOVANIC: Hood morning. I'm Olivera
20 Jovanic, DHB support staff.

21 MS. MARTIN: I'm Liz Martin, DHB support
22 staff.

1 MS. PEABODY: Good morning. Hillary
2 Peabody, also DHB support staff.

3 COLONEL GRIMES: Good morning. I'm
4 Jamie Grimes and I'm the national director,
5 Defense and Veterans Brain Injury Center.

6 DR. LEDNAR: Thank you everyone for
7 those introductions. Before we begin our formal
8 agenda, Ms. Bader has a few administrative remarks
9 that she would like to share with us. Ms. Bader?

10 MS. BADER: Thank you. Good morning
11 again and welcome. Please sign the general
12 attendance roster on the table outside of the room
13 if you have not already done so. Additionally,
14 for those not seated at the U-shaped table, there
15 are handouts that are provided at the sign-in
16 table right outside the door. This is an open
17 session. It is being transcribed. Please ensure
18 that you state your name and speak into the
19 microphone so that our transcriber can accurately
20 record your comments.

21 We will be finishing earlier than
22 originally scheduled today. Our plan is to finish

1 around noon. When we finish the formal session we
2 will then have an administrative session and we'll
3 have a working lunch for the Board members,
4 ex-officio members, service liaisons and DHB
5 staff. It's good news that we're finishing a
6 little bit ahead of schedule. For those of you
7 who are local and were not able to get out and
8 vote before the meeting, please vote this
9 afternoon. Thank you and we look forward to a
10 great meeting.

11 DR. LEDNAR: Thank you, Ms. Bader. We'd
12 like to start the meeting, and the Board is
13 grateful to have with us today Vice Admiral John
14 Mateczun, commander, Joint Task Force National
15 Capital Region Medical. Admiral Mateczun has
16 served as Joint Staff surgeon and medical advisor
17 to the chairman of the Joint Chiefs of Staff, was
18 U.S. Delegate to the NATO Committee of Chief of
19 Medical Services, as well as on the Joint Staff
20 during Operations Noble Eagle, Enduring Freedom
21 and Iraqi Freedom. Vice Admiral Mateczun today
22 will share with us a progress report on the Walter

1 Reed National Military Medical Center. Admiral
2 Mateczun's slides may be found in the binders
3 under Tab 8. For our guests, copies of the
4 handouts have been available outside the room.
5 Thank you. Admiral Mateczun?

6 VICE ADMIRAL MATECZUN: Thank you, Dr.
7 Lednar, Dr. Poland, Ms. Bader, General Myers, my
8 old boss on the Joint Staff who really headed up
9 all those projects that Dr. Lednar was just
10 reading. I'm here today to update you on our
11 progress in enhancing the world-class health care
12 capabilities in the National Capital Region. I'm
13 going to tell you some of the background. I think
14 many of you have been through these briefings
15 before. We've been at this for 3 years now, going
16 on four, and tell you what the components are of
17 the Comprehensive Master Plan that will achieve
18 the last of the world-class capabilities or
19 attributes and then tell you something about how
20 we're doing on some other projects as well.

21 It seems like just yesterday but here we
22 are and there's under a year left to go, 321 days

1 I think until September 15, 2011, when the statute
2 requires that we complete the BRAC projects. We
3 were formed in 2007, the Joint Task Force, to
4 execute the BRAC projects while continuing to
5 provide casualty care in the capital region. Then
6 in October 2008, the fiscal year 2001, NDAA
7 required an independent review of the BRAC plans
8 for Walter Reed and Fort Belvoir. Actually that
9 was the fiscal year 2009 NDAA. In July 2009,
10 there was a panel of the Defense Health Board that
11 completed the independent review. Dr. Ken Kizer
12 headed up that panel. That came to the department
13 in July and went over to the Hill. The department
14 endorsed those recommendations in October, and
15 then a few weeks later the fiscal year 2010 NDAA
16 codified the DHB definition of world class so it's
17 now a statute and required a Comprehensive Master
18 Plan for the National Capital Region on how we
19 were going to achieve that status at the Walter
20 Reed National Military Medical Center-Bethesda.

21 The Comprehensive Master Plan mandated
22 was provided on April 23 this year to Congress as

1 a roadmap to get to those additional world-class
2 attributes that were identified by the Defense
3 Health Board. And then DOD also approved a
4 supplement to that Comprehensive Master Plan which
5 was also mandated by the fiscal year 2010 NDAA.

6 Here are the primary components of what
7 went into the Comprehensive Master Plan,
8 world-class construction projects at Bethesda, and
9 I'll go into some detail about that; the National
10 Capital Region organizational and budget
11 authorities; how are we handling IMIT; and our
12 civilian personnel. Here's an update on the
13 construction projects. I have a lot of pictures
14 that I'll be showing you as well on how the new
15 construction projects are going and some of the
16 renovations. The Comprehensive Master Plan that
17 was submitted to Congress in April and reiterated
18 in August identifies \$829 million in facility
19 projects on the Bethesda campus that includes the
20 design of temporary facilities, additional
21 parking, outfitting, transitional costs and the
22 base infrastructure upgrades needed to meet the

1 attributes. In sum, there will be new
2 construction of 560,000 square feet, 325,000
3 square feet, and I'll show you a picture, are in
4 poor or failing condition and they will be
5 demolished and it would also renovate an
6 additional 120,000 square feet of clinical space.
7 The primary drivers of the space requirements are
8 the identified attributes of single-patient rooms
9 to be in a world-class standard. So at the end
10 state of the BRAC there will still be 50 double-
11 patient rooms at Bethesda and in order to achieve
12 the new standard we have to convert those 50
13 double-patient rooms into 100 single-patient
14 rooms. We're already in the process of renovating
15 the operating rooms to reach the size required to
16 be world class, but that has also edged some of
17 the logistical infrastructure out from around the
18 O.R.s and so we have to go back and add some more
19 space to do that. That and a simulation center
20 and the space required for simulation are the
21 primary drivers of the space that we need.

22 Right now the department is estimating

1 that these projects will begin in fiscal year 2012
2 and be completed by fiscal year 2018. Right now
3 there is a saturation of construction and that
4 certainly includes construction workers coming on
5 to the Bethesda campus and that will last through
6 the end of BRAC. We have a lot of projects that
7 we've got to finish up. The Navy has determined
8 that a new environmental impact statement will be
9 required before this construction can begin so
10 that we're going to have to do a lot more
11 coordination with community organizations before
12 we can get to that environmental impact statement.

13 Costs will continue to be refined. If
14 there's one thing I've learned it's that
15 construction costs are always an estimate even
16 when you're through. We're going to complete the
17 planning for all of the facilities on the campus
18 by the end of this year and then design will get
19 underway.

20 This is the current campus on Bethesda.
21 For those of you who are familiar, Wisconsin
22 Avenue is right out here down at the bottom of the

1 slide. This is the new outpatient building,
2 Building A, and this is the new Building B which
3 has a lot of intensive care units, some operating
4 rooms and some other infrastructure. These are
5 the existing clinic buildings and inpatient
6 buildings on the campus and this is some of the
7 historic part of the campus back in here. We have
8 within the department a facilities condition index
9 which the Under Secretary for Acquisition
10 Technology and Logistics has updated. This FCI
11 index which you'll see over here scores the
12 buildings based on this new scoring system that
13 we're using within AT&L. You'll see what the
14 Defense Health Board subcommittee and Dr. Kizer's
15 committee saw in particular. This is all red so
16 this is poor or failing infrastructure based on
17 facilities' conditions which is exactly what the
18 Defense Health Board said and is exactly what we
19 need to work with. This is where the inpatients
20 are and so we're going to have to build and move
21 functions out of here so we can get all of the
22 beds that we need to into this space and some into

1 this space. Then the plan right now would really
2 be to do new construction of all of this. This
3 would all come out, that's the 325,000 square feet
4 that needs square feet that needs to be demolished
5 and build 560,000 square feet in there.

6 This is a very telling slide in terms of
7 the projects. The MILCON projects are going on.
8 These are the most current MILCON projects in
9 Buildings A and B, MILCON military construction
10 funding. Then there wasn't any previous military
11 construction funding going on on the campus after
12 1971 when these buildings were built so that we
13 have a lot of facility restoration and
14 modernization that we need to do.

15 This is the campus as it exists today.
16 There is a lot of building going on. The last
17 time I was here I didn't have these slides.
18 You'll see that this is the outpatient building
19 now complete. It is actually getting turned over.
20 It is in the process now of outfitting. There is
21 a parking garage here. This is Building B which
22 is going to start being outfitted very soon as

1 well. This will be completed in outfitting by
2 December as will this so that all of the equipment
3 will come in and be installed, tested and it will
4 be ready for people to move out of these current
5 clinic buildings over into the clinic space over
6 here. The green is what was phase one. There is
7 some medical swing space over here where
8 orthopedics and O.T. Are now, but they won't be
9 needed right away for anything else.

10 This is the NICOE. I saw that you had
11 an update. The NICOE saw their first patients 3
12 weeks ago and now are starting to sequence
13 patients through and over the next 2 weeks we'll
14 get up to a patient census of 10 next week in
15 there and then we'll ramp down for the
16 Thanksgiving holiday and then back up in December.
17 Staff is coming in at a very good pace. These
18 three Fisher Houses are 20-unit Fisher Houses and
19 this was donated by the Intrepid Foundation. This
20 is donated by the Fisher Foundation.

21 And Building 3 has been accepted by the
22 Navy now and they are doing some modifications to

1 make sure that it meets code and then it will be
2 ready to primarily house patients and families
3 that will be coming in to the NICOE and the other
4 two will be turned over shortly. They are very
5 beautiful houses, 20-unit houses each so that
6 that's 60 new units for family housing coming onto
7 the campus. This is a new parking garage. We've
8 just torn out this part of the old campus and are
9 starting construction on that now. This is a
10 massive parking garage with almost 1,300 parking
11 spaces. It will be done by the time the BRAC is
12 finished.

13 Then on phase two we have the wounded
14 warrior lodging. I'll show you a slide on that.
15 We have an admin building, a 70,000 square foot
16 workout facility and pool and a parking garage
17 going back into this part of the campus right
18 here. This of course is the university if you
19 want to get oriented to that. When I say that
20 we're saturated with construction, I mean we're
21 saturated with construction right now.

22 This is a back look at the campus

1 looking at it from the other side. This is
2 Wisconsin Avenue out front. Right now many of you
3 may know that there's a Medical Center Metro stop
4 and the National Institute is right across the
5 street. The Washington Metropolitan Area Transit
6 Association has done a study on how we can
7 pedestrian traffic across Wisconsin Avenue which
8 is not an easy thing to do. The three most
9 crowded intersections in Montgomery County
10 surround the Medical Center: One up here on
11 Wisconsin Avenue, one kind of back over here to
12 the bottom on Connecticut which you can't see and
13 then on Jones Bridge Road over on this side at
14 Jones Bridge and Connecticut. So there are
15 massive amounts of traffic coming through there.
16 It is hard to get across Wisconsin Avenue.

17 They've come back with a proposal for
18 either a short tunnel or shallow tunnel under
19 Wisconsin Avenue, a deep tunnel with an elevator
20 coming under Wisconsin Avenue or we thought they
21 were going to go for a bridge, but they think that
22 that impairs the site picture so they're proposing

1 an underpass that would actually divert Wisconsin
2 Avenue under something that goes across there.
3 That of course would be a very expensive option.
4 The department has \$20 million committed to
5 working with them on whatever it is they choose to
6 do in working with that traffic mitigation.

7 We also have a proposal in to mitigate
8 traffic through business processes. We have a
9 million refills a year that we do and trying to
10 divert that traffic and not have people have to
11 drive to our places but taking a look at mail
12 order refill is one way that we can not have
13 traffic come on to the traffic campus. It's a
14 very busy campus.

15 This is the admin building. Let me go
16 back and show you were that is just so you can
17 see. That's this building right over here, this
18 large complex so that this is all administrative.
19 This is the end state down here with the green
20 roof. This was an historic building. Some of you
21 may have actually worked in this building. It
22 used to be the Navy Medical R&D Command. It was

1 completed by the same architect who's done the
2 tower. They call it a curved façade. It's
3 actually an angled façade. It's not curved. But
4 it's historic and so we had to maintain the
5 façade. They decided to maintain the whole
6 building. It had asbestos that's all mitigated
7 and they're renovating inside there now. You'll
8 have these other two floors that will come down
9 with a green roof and then a gymnasium and parking
10 complex so that this will be a very
11 environmentally friendly part of the campus.

12 Tower cranes are my friends. I see new
13 tower cranes popping up all the time, but these
14 tower cranes are constantly working. They were
15 working until dark the other night. They have to
16 stay synchronized as they turn. They turn across
17 each other. It's kind of interesting to watch.
18 Our building, the building where we work out of is
19 right over here. Luckily we are in what is called
20 a no-fly zone so they can't turn these over our
21 building which gives us a little bit of confidence
22 in what's going on.

1 This is the completed part of the
2 outpatient building, just a couple of shots. You
3 can see here this is one of the lobbies what it
4 looks like. It's really an extraordinary
5 building. This is looking into a skylight tunnel
6 that comes all the way from the center of the
7 roof, down all the way through the floors of the
8 complex to bring light into each of the floors so
9 they have this central corridor. This is what the
10 bottom of it looks like with the very nice Zen
11 garden and mosaic that has been put in down there.
12 These are also very near where the new MATC, the
13 amputee and prosthetics care center will be.

14 This is the new wounded warrior lodging
15 that is going up. This is the concept with two
16 towers and an admin building and dining hall.
17 These are each of the towers as they're going up
18 and the admin building will be across back here.
19 This is the concept. We've now moved into a new
20 business and that is rehabilitation. Before
21 Operation Iraqi Freedom we really didn't
22 rehabilitate patients, prosthetics and amputee

1 patients in particular and return them to active
2 duty. Now, however, we do and so that requires
3 that we adjust. Previously we didn't have to have
4 room for people to return to activities of daily
5 living and we didn't need to train in that, they
6 would be discharged to go to a VA and transition
7 there. Now we do need to discharge patients from
8 the hospital not completely ready to assume
9 activities of daily living, particularly the
10 amputees.

11 We have a lot of people in limb salvage
12 and/or traumatic brain injuries and they may need
13 a nonmedical attendant which is an evolving
14 concept for us as well. A nonmedical attendant
15 many of you is a construct under the Joint Federal
16 Travel regulation which allows us to pay for
17 sending one family member with a casualty some
18 place, but now they've turned it into a functional
19 entity and that is that they actually are a
20 nonmedical attendant who helps people in these
21 circumstances. The Army uses this concept
22 extensively, the Marines and the other services to

1 a lesser degree.

2 This is what one of the suites would
3 look like. All of the rooms in these towers are
4 constructed as suites of two bedrooms, a bedroom
5 on either side with a common living area in the
6 middle which has a small laundry, a kitchenette
7 and the other things that we need to ease people
8 in transitioning to their new outpatient
9 environment. This has been very successful.
10 People usually don't want to leave the campus.
11 We've been helping many of them transition into
12 apartments in the local community. They usually
13 don't want to, and then once they're there they
14 never want to leave those apartments. As they
15 gain independence and confidence at being able to
16 navigate in that world, they're very happy to be
17 moving through the steps that it takes to readjust
18 back into the community. These are going to be
19 extraordinary. There are 300 of these rooms, 150
20 suites. If necessary we can put a person and a
21 nonmedical attendant in there or two outpatients
22 if we need to. These are completely ADA compliant

1 rooms and meet every standard that we can for
2 taking care of our folks.

3 Here is the concept. This is just a
4 conceptual drawing on how we would achieve the
5 world-class standard. I showed you that area that
6 we needed to take out the buildings and this is
7 what would go in there. It's still very
8 conceptual. You can see that this arranges the
9 campus on axes which will be much easier for
10 patient and staff navigation and puts a tower back
11 in here. We're still looking through the
12 possibilities for aligning behind the tower
13 because the site picture when you look up a slope
14 from Wisconsin Avenue it's important to the
15 National Capital Planning Commission that has to
16 approve the plan, but that would be the idea right
17 now.

18 Let me switch to Fort Belvoir. The Fort
19 Belvoir Community Hospital plans were seen to be
20 world class. In fact, this is the leading
21 exponent of evidence-based design in the country
22 right now. It's moving right along. The plan is

1 a parking garage on either side and there's
2 nothing parking and south parking. Those are up
3 and functional. There are two clinic buildings on
4 either side. You see these clinic buildings which
5 are now finished and the skin is on. This is a
6 thermal skin which recreates the look of brick or
7 terracotta but has much better properties and is
8 easily replaceable. Should they become damaged
9 there is an air gap behind that terracotta-looking
10 skin as well and so it's very environmentally
11 friendly. These scoops which are sort of the
12 signature as you look at the campus from outside
13 are rainwater collectors. They serve a double
14 function in that they air conditioners and air
15 handlers and other equipment are underneath them
16 and covered so that you don't see the air handlers
17 on top of the buildings. They collect rainwater
18 and put it down into cisterns underground.
19 Ultimately they'll water these gardens that are in
20 between the projects.

21 This is nine holes of a golf course.

22 It's about the size of the Springfield Mall for

1 those of you who know Northern Virginia. It's
2 about an aircraft carrier in length from here to
3 here and another aircraft carrier from there to
4 there so that this is an extraordinarily large
5 medical campus. This is 7-story tower which is
6 the inpatient building and will be the last to
7 completed with 120 beds, 10 O.R. and 30 E.R.
8 spaces to put in there. This is the central
9 utility plant which will feed the energy needs,
10 and this is all going to be parking out in the
11 front at the end so that there will be a lot of
12 parking. There's good way finding. Coming in
13 you'll see each of them has a name. This is the
14 Meadows, the Sunrise, the Oaks, the Eagle and the
15 River so that these buildings are themed as you
16 walk through them and walk through the building
17 you'll be able to find where it is that you're
18 going. We're trying to make sure that people who
19 are going to one of these buildings park over here
20 instead of here because it's kind of a long ways.

21 These are some of the current pictures
22 from the outside. It's an extraordinarily looking

1 facility. This is the back of the inpatient
2 tower. You can see the skin is almost finished on
3 it. The towers are coming up. They're working on
4 finishing the interior of that now and we are
5 moving to start outfitting in the clinic
6 buildings. The clinic buildings is that swoop I
7 told you about. We're going to start outfitting
8 in those clinic buildings here this month and
9 we'll have those clinic buildings ready but we're
10 not going to be ready to move out of Fort Belvoir
11 until we get parts of the tower completed because
12 we have to have ancillary services available
13 before we can move some of the other services.

14 This is what some of the interiors look
15 like. I didn't hear anybody say that they were a
16 pediatrician. This is clearly a PEDs ward with
17 turtles and duckies as you walk down the way.
18 This is the concept of what it looks like as you
19 come in. The idea is that you walk into a foyer
20 and then move into these fairly quiet spaces that
21 will then move you back into the clinic rooms very
22 much like the Disney on-stage/off-stage concept.

1 Support, supply and logistics will not be on stage
2 if you will where the patients are waiting.

3 People carrying blood and doing other things will
4 be back in the back moving through the back part
5 of the clinic that will be back there in those
6 corridors along the back. The staff rooms are in
7 the back and all of the patient rooms are along
8 the side. It's a very nice concept. This is the
9 P.T., physical therapy, pool. It's an

10 extraordinary pool. These are connectors between
11 the buildings. Ultimately there will be gardens
12 here. You can see the light. There's light
13 everywhere. This is one of the murals. I don't
14 know. This is one of those things where you
15 delegate a lot of things to people and they pick
16 murals. This is in the PEDs ward and I didn't
17 know if it was a scary tree or a friendly tree.
18 You can decide when you got. But it does have
19 bold, distracting colors is what the design people
20 were looking for.

21 Also going up out at Fort Belvoir to
22 support the wounded warrior lodging is a brand new

1 complex of completely ADA-compliant rooms which
2 are going to be built something like along the
3 lines of what you saw at Bethesda in these towers
4 and with the admin building. This will be
5 primarily a warrior transition unit as it's an
6 Army base and the vast bulk of the casualties that
7 we handle in the capital region are soldiers at
8 the moment. All of that is changing as the
9 current conflict changes and I'll be glad to
10 update you on how we're doing there. That's some
11 of the pictures of the construction and how we're
12 getting to world class and in particular how we're
13 going to take care of the wounded, ill and injured
14 coming back.

15 Budgetary authorities. One of the
16 things that the Defense Health Board panel
17 recommended was that you have to have an alignment
18 of organizational and budgetary authorities in
19 order to be able to achieve world class. I am in
20 complete agreement with that and this is what
21 we've done. I now have what's known as
22 operational control over the Walter Reed Army

1 Medical Center, the National Naval Medical Center
2 and DeWitt Army Community Hospital. Those are the
3 hospitals that are going to collapse into the new
4 Walter Reed National Military Medical Center and
5 the Fort Belvoir Community Hospital. I have the
6 authorities necessary to reorganize, realign and
7 direct moves with those folks. It's kind of a
8 daunting task. There are about 9,000 people in
9 those facilities so that's a lot of people relying
10 on us to get this done correctly.

11 Post-BRAC the Joint Task Force will
12 maintain operational control over the Walter Reed
13 and Fort Belvoir complexes. There is a move to
14 call this Walter Reed National Military Medical
15 Center-Bethesda and put a B on the end. If you
16 think about it, it incorporates both the Walter
17 Reed and Bethesda parts of the past and so
18 although it's not in the law, that may be
19 something that comes into common usage over time.
20 Of the other outpatient clinics, there are about
21 37 other clinics in the region. I still have
22 what's known as tactical control over them but not

1 OPCON. The Chairman of the Joint Chiefs has
2 directed that we look at that after the BRAC and
3 that we get through the BRAC before we move any
4 further.

5 We have single organizational and
6 budgetary authority so that we get synergies for
7 more effective and efficient operation that aligns
8 with the Defense Health Board's recommendations
9 which they called foundational that somebody has
10 to be empowered with singular authority. We have
11 worked with Health Affairs to get all of the
12 budget aligned. This year we've got all of the
13 budget for these three hospitals aligned and that
14 is an operations and maintenance budget of around
15 a billion dollars and will be directing the
16 operations in those three hospitals in the funds
17 flow.

18 IMIT. I'd like to say I'm a lot smarter
19 about smart suites, but smart suites are always
20 surprising. We do have smart beds that we've put
21 in. We've got the electronic clinical dashboard
22 which we're getting the infrastructure to put in

1 and real-time location system technology. You can
2 never tell. People always have questions.
3 Technology can be misused. I'm not a Luddite and
4 I'm not going to trash technology, but you have to
5 be careful.

6 I received a question up on the Hill
7 about this one that utilizes real-time location
8 system technology. Part of putting things in was
9 we wanted to make sure that our staff had RFID
10 tags. When you walk into a patient room the
11 patient has a right to know who you are, what
12 you're doing there and what your job is. The idea
13 is that this would flash up on the screen and they
14 could see who you are and what your job is. The
15 question I got on the Hill was are we going to use
16 this to monitor staff, in particular nursing
17 staff? I said no we're not, but now I have to go
18 back with assurances that we're not going to use
19 this to see who's taking breaks or doing other
20 kinds of things. Interesting questions about
21 technology.

22 The Joint Medical Network. Part of the

1 difficulty that we have in moving into the future
2 is that the DeWitt and Fort Belvoir complexes are
3 linked back to Walter Reed as their hub for
4 servers and other IT so that we have to transition
5 that platform to another hub. We've got the
6 funding and we're putting together the fiber which
7 is another one of the things we need to do to lay
8 down this new network. We're still working
9 through some of the questions about how we move
10 images. This is not just us in the capital
11 region. How can we make sure that images are
12 accessible in a timely way wherever they need to
13 be? We don't have completely uniform ways of
14 storing and moving all images. We're getting
15 closer. In particular these things you see,
16 cardiology, ophthalmology, endocrinology and
17 nuclear medicine are going to have arrive at some
18 standards.

19 Civilian personnel are key to what goes
20 on. We have about 4,200 civilians who work in the
21 hospitals that we're talking about at the medical
22 centers. This has been a key part of the

1 department's effort. We needed to retain that
2 workforce at Walter Reed so that they didn't
3 attrite because we're taking care of casualties
4 while we're doing this transformation so that we
5 needed that capability. Then we need them to
6 staff these Medical Centers of the Future. They
7 are an experienced and skilled workforce and we
8 can't afford to have to go out and recruit all of
9 them again.

10 This is the first guaranteed placement
11 program for a BRAC site of this size. It's been
12 tried in the department and in particular it is
13 these 2,200 employees are Walter Reed that we're
14 focusing on with the guaranteed placement program.
15 We worked very hard for 2 years at identifying the
16 spaces, that is the jobs that were going to be in
17 each of these new hospitals, then we matched faces
18 to those spaces and then we notified them in June
19 of this year about where it is that they were
20 projected to be in the future state. We sent out
21 all those letters. They didn't have to send back
22 a letter if they were happy with where they were

1 going. Nevertheless, you'll see that we got back
2 a tremendous number of responses particularly from
3 this 2,200, but from everybody else saying yes I
4 am happy with what's happening here. We certainly
5 have 209 people here who didn't like the location
6 and we're working on that every day.

7 We've got another year to go before we
8 have to move people so that we're working to try
9 to make sure that in as many cases as we can
10 people are working at the location that they want
11 to work out of. That's an extraordinary
12 acceptance rate we thought and in a program of
13 this size with that many people, I can tell you
14 it's a testament to the commitment of our
15 workforce to stick with us, and as long as we keep
16 our covenant with them to try to provide a job and
17 have it be in the place that they want to be we
18 think we can continue to work this. We do our
19 moving to one single DOD civilian personnel
20 agency. These people work in at least two and
21 sometimes three or four different civilian
22 resource organizations, Army, Navy and others so

1 that we're combining them into one and we're just
2 finishing up the coordination on the authorities
3 that it will take to do that. Then our plan is to
4 transition them into that new support structure in
5 April, make sure that their pay is all right and
6 that they don't have any problems before we begin
7 the move in the summer of 2011.

8 In conclusion DOD is committed to
9 enhancing and improving the world-class health
10 care capabilities of the NCR. We're working on
11 this integrated health care delivery system and
12 understand that it will provide more efficient and
13 effective health care. Casualty care will always
14 be our top priority. We express our appreciation
15 to the Defense Health Board for support through
16 the transformation of military medicine in the
17 NCR. It's been a 3-year journey. We have another
18 year to go before the end of BRAC and we certainly
19 have a lot to do in that period of time. People
20 ask me often about risk, what's the risk of
21 finishing the BRAC? I think that people tend to
22 see just what's left in front of them to do and it

1 looks like a lot of daunting tasks.

2 However, my risk assessment is that the
3 majority of risk is in the past, that is, before
4 steel went up on these buildings, before they were
5 outfitted, before we bought the furniture and had
6 the equipment lists to put all of the equipment
7 that we need into them and before we had the
8 money. That was when there was a lot more risk so
9 that the risk is more finite today although in
10 some ways that makes it more visible to people and
11 we need to make sure that our people internally
12 and all of the folks who work in oversight with us
13 understand where it is that we're going.

14 That concludes the presentation that I
15 have. I do want to tell you just a little bit
16 about what we're doing today. We have a lot of
17 casualties coming back from Afghanistan. The
18 number of amputees has increased coming back.
19 During the Iraq conflict we had a number of IED
20 and complex orthopedic trauma cases coming back
21 and a number of burn patients. The number of burn
22 patients has diminished dramatically. We don't

1 have very many burn patients coming out of
2 Afghanistan.

3 We do have a lot of amputees coming out
4 so that the proportion of critical care air
5 transport patients who come back in as amputees
6 has risen. Also the numbers of multiple
7 amputations have grown as well. In Iraq they were
8 running under 25 percent, generally around 19.
9 They're up above 25 now and on a given day maybe
10 more. In fact, we have four quadruple amputees
11 that we're caring for now so that the number of
12 double amputees and triple amputees is also
13 increasing. We're working on a model to try to
14 understand resource consumption and requirements
15 for those amputees. There is really very little
16 study on how much it takes to take care of a
17 double amputee. Is it one-and-a-half times as
18 much or is it three times as much as it takes for
19 a single amputee? We're working with that very
20 diligently.

21 We're also working on a model that tries
22 to identify modeling for the capacity that we'll

1 have in the O.R., the I.C.U. and med surg beds and
2 we've just presented that to the Joint Staff and
3 to the Under Secretary for Personnel and Readiness
4 to take a look at during the transition and see if
5 we're going to have the capability to take care of
6 that. In addition these complex orthopedic trauma
7 cases are something that we've come to understand
8 that we have to keep a much closer eye on. We
9 have a team at Bethesda of four orthopedic trauma
10 surgeons at Walter Reed and four at Bethesda.
11 Right now we think that they're comfortable
12 handling eight amputees a month. Ten stretches
13 them and 12 is probably too much. They can't
14 continue to see both the outpatients do their
15 washouts in the O.R. and the other things that
16 they have to do and handle the inpatients and
17 incoming load at some point and we're working
18 diligently to try to define what that point is.
19 There's no work on it and so we think that we're
20 coming to understand that more and we'll certainly
21 be happy to share that information as it becomes
22 available. You'd be proud of all of the great

1 staff there that are working to take care of these
2 casualties who come back and the great staff that
3 are working diligently to make sure that they have
4 the best in facilities as they come back. That
5 concludes my presentation and I'm ready for any
6 questions that you might have.

7 DR. LEDNAR: Admiral Mateczun, thank you
8 for that brief. I think for a number of us on the
9 Board who've been following the progress of this
10 issue, a lot has been accomplished so thank you
11 for that. I might ask if Dr. Kizer might start if
12 you have any comments or questions, Dr. Kizer,
13 that you'd like to ask.

14 DR. KIZER: Thank you, and thank you
15 Admiral Mateczun. That's a great overview. I
16 think it's been gratifying to see the response to
17 the committee's report and I think the general
18 acceptance of what was put forth and I certainly
19 commend Admiral Mateczun for his leadership in
20 operationalizing many of the recommendations.
21 Since the subcommittee has not met since I believe
22 March 2009, and has not had the opportunity to

1 review the Comprehensive Master Plan or anything,
2 I don't think that the subcommittee can weigh in
3 officially on any of that. But again I think it's
4 gratifying to see the progress that is being made.

5 I have one caveat that I would put
6 forth. The report I think was quite clear that
7 the majority of what is required to achieve world
8 class is unrelated to construction and facility
9 design. As important and as visible as those
10 things are, the majority of what will actually
11 achieve world class is what was described as the
12 invisible architecture, the culture, the processes
13 of care and other things and I'm not sure where
14 any of that stands at the moment. There were a
15 number of specific recommendations in that regard
16 and perhaps at a future meeting we can hear more
17 about how those things are being addressed.

18 DR. LEDNAR: Thank you. Are there other
19 questions and comments? Dr. Kaplan?

20 DR. KAPLAN: Thank you for a very nice
21 report. I wanted to clarify one thing that you
22 said at the end of your report and I'm not sure I

1 understood it correctly. You said that the number
2 of IED injuries had increased, that the number of
3 patients coming back had increased if I understood
4 you correctly from 19 to 25 percent. Does that
5 take into consideration the denominator, the
6 number of troops on the ground?

7 VICE ADMIRAL MATECZUN: Let me clarify
8 that the number of casualties coming back from
9 Afghanistan has increased. The number of
10 casualties coming back from Iraq has decreased.
11 The number of people from either war who have come
12 back with multiple amputations has increased from
13 19 percent to more than 25 percent.

14 DR. KAPLAN: That's an absolute number
15 and not relative to the number of troops on the
16 ground?

17 VICE ADMIRAL MATECZUN: That's correct.
18 The number of amputees is the denominator.

19 DR. KAPLAN: Thank you.

20 DR. LEDNAR: General Myers?

21 GENERAL MYERS: Thank you, Admiral
22 Mateczun. That's a great brief. Could you

1 comment on the USO and where they're going to put
2 their centers? I assume you know a lot about
3 that. I also know a lot about it.

4 VICE ADMIRAL MATECZUN: Yes, sir. We're
5 still working through that. The USO has proffered
6 a building, an extraordinary new USO building to
7 the Navy. The Navy has still not finalized the
8 site. They're planning on accepting the proffer
9 and have not finalized the site. Right now it
10 looks like that construction would begin after the
11 BRAC is completed.

12 GENERAL MYERS: Just for the group, and
13 you may want to get the USO to brief it because
14 while it's nonmedical we think it's essential to
15 the health and well-being of the patients out
16 there. What the USO has committed to do is a
17 capital campaign to raise \$100 million to build
18 two buildings -- one at Bethesda and one at Fort
19 Belvoir -- that would hopefully be close to where
20 the wounded warriors are housed. They will be
21 nonmedical, but the kind of place where you can go
22 with your family, there will be food services and

1 other things available, entertainment sorts of
2 things, really a departure from what the USO has
3 done in the past. But given the fact that we've
4 been at war for 10 years, this whole notion of
5 enduring care came up and with our new leadership
6 at the USO they want to move in this direction.
7 It's going to be a huge commitment.

8 The construction companies, Turner and
9 Clark, we'll try to get them to provide in-kind
10 services to build these. I don't know how much
11 they're going to do, but they're both very
12 receptive to that, so it's a huge deal. The one
13 criteria we set for this whole thing is that when
14 an injured soldier or his family walks in that
15 there's a wow factor like they've never seen
16 before. I've already seen the art and they're
17 going to be beautiful. They will be a good
18 adjunct and a place to go which is a nonmedical
19 setting where they can enjoy their family and
20 friends, entertainment and other things and be a
21 hub where all the other veteran's services that
22 are out there through the hundreds of

1 organizations that help wounded warriors and other
2 veterans will have a place to be so that that is
3 the concept. You may want to get a pitch on it.
4 It's a big deal for the USO. A \$100 million
5 campaign is a big deal.

6 DR. LEDNAR: What I hear in General
7 Myers' concept is consistent with what Dr. Kizer
8 was talking about, the invisible architecture.
9 Part of the culture of care for our wounded
10 warriors and their families is in part what
11 happens in the medical spaces and the medical
12 processes and part of it is what happens in the
13 whole process of getting care, getting to a
14 campus, housing, how the family supported and
15 these other things so that I see it as part of a
16 connected whole. We look forward to learning more
17 about the USO's activities. Dr. Parisi and then
18 Dr. Silva?

19 DR. PARISI: I had a question for you
20 regarding pathology services for Fort Belvoir and
21 DeWitt Hospitals. Are those going to be
22 independent, free-standing pathology units or are

1 they going to be tied to the main Bethesda campus
2 and to the JPC or how do you envision that?

3 VICE ADMIRAL MATECZUN: Laboratory
4 services at Fort Belvoir are separate. There will
5 be some integration between them in terms of
6 services, the Joint Pathology Center for instance
7 will be providing subspecialty consultation
8 primarily through the Bethesda campus and we will
9 keep it administratively organized to do that.
10 Otherwise they'll have their own separate
11 laboratory down at Fort Belvoir.

12 DR. LEDNAR: Dr. Silva?

13 DR. SILVA: Admiral, thank you for an
14 update. I have two questions. One, if everything
15 goes as planned, you're done in 2018 when
16 everything is done?

17 VICE ADMIRAL MATECZUN: Yes. The middle
18 portion of the campus would be started in 2012 and
19 done in 2018. These BRAC projects will be done in
20 2011.

21 DR. SILVA: Correct. When you're
22 finally done, what is the big number for the cost

1 of everything that we could hang our hat on? I
2 know you're going to have overruns and that's
3 common.

4 VICE ADMIRAL MATECZUN: Right now it's
5 about \$1.4 billion for the current projects on the
6 Bethesda campus and that would add right now \$829
7 million.

8 DR. SILVA: The second thing is I'm in
9 the part of the world where we have what's called
10 California crazies. They can tie up projects
11 related to environmental studies like you can't
12 believe. Are you sniffing at tea leaves and do
13 you expect much trouble there?

14 VICE ADMIRAL MATECZUN: The Montgomery
15 County population and the Bethesda population are
16 very sensitive to traffic and that is their
17 primary concern. There's not much else that they
18 ever bring up. So with the National Institutes
19 across the street they're vigilant after those
20 projects were built and keeping a very close eye
21 on traffic coming in. If we can divert refill
22 pharmacy traffic off of our campus we'll be able

1 to move 8 percent of the total traffic that will
2 be coming on to the campus so we think that that's
3 an extraordinary measure. It's certainly going to
4 be a better traffic mitigation than anything else
5 we can do just by our own actions so that we're
6 trying to work with that very carefully with the
7 local Bethesda folks. There is the saying that
8 all it takes to stop a project is a postage stamp
9 and a request for an injunction but we've been
10 very fortunate in our relations and we've tried to
11 make sure that we're as transparent as we can be
12 with the Bethesda campus.

13 DR. SILVA: Thank you.

14 DR. WALKER: Admiral Mateczun, this is
15 an outstanding facility for the needs of the
16 current war. How much flexibility is there? I
17 don't have in my own mind what the needs of the
18 next war are going to be.

19 VICE ADMIRAL MATECZUN: I was walking
20 around the campus yesterday and looking at
21 Buildings 9 and 10 which came out of the Vietnam
22 War and they came right at the end of the Vietnam

1 War and now we're building the capability.
2 Buildings 9 and 10 have certainly have had
3 extraordinary use over the last 35 years so that
4 I'm not too concerned. We've done five studies
5 now in the National Capital Region taking a look
6 at the beneficiary population. We have in excess
7 of 500,000 beneficiaries here in the local area
8 almost 300,000 of whom are enrolled in the TRICARE
9 system so that there is plenty of patient
10 population out there to fill the beds. There is
11 not going to be an excess of beds. In fact,
12 what's happening now as the casualties are coming
13 in is that people are deferred out into
14 private-sector care so that our private-sector
15 care bill is over \$500 million now in the National
16 Capital Region. We'll be able to bring most of
17 those cases back in. We have 40 percent of the
18 Army's Graduate Medical Education Training
19 Programs and over a third of the Navy's Graduate
20 Medical Education Training Programs that we have
21 to support between those two facilities. So there
22 are plenty of patients out there and the patient

1 demand will be there.

2 In addition, we're doing some new things
3 that we think will turn into a referral center for
4 many of our patients. We're working to partner
5 with the National Cancer Institute in the
6 Comprehensive Cancer Center that we're standing up
7 for the first time. This will be the first
8 Comprehensive Cancer Center in the military health
9 system. The number of cancer patients and the
10 number of Centers of Excellence that we have will
11 certainly I think be able to bring in patients or
12 recruit them. We do transplants and we do some of
13 the other referral business that will need to come
14 in so that I don't think we're overbuilding
15 infrastructure in any sense right now.

16 DR. LEDNAR: We have time for one more
17 question. Dr. Lockey?

18 DR. LOCKEY: I wanted to build on the
19 Disney on- stage/off-stage concept in relationship
20 to this fairly comprehensive and large medical
21 center. Who is addressing ease of access for
22 visitors and for patients in regard to finding

1 locations they need to go and not getting
2 frustrated? Are you going to follow the Disney
3 concept for that are is somebody else looking at
4 that issue?

5 VICE ADMIRAL MATECZUN: Dr. Kizer's
6 panel actually listed those concerns as part of
7 the attributes that you had to get to to get to
8 world class. In getting to the Comprehensive
9 Master Plan for instance we have architects,
10 patients, a lot of folks looking at how we can get
11 to ease of way finding, what makes it friendly for
12 patients and how can we do that. At the Fort
13 Belvoir complex they've gone to extraordinary
14 lengths to adjust to that with the themes that
15 they've got like how people will flow into the
16 parking garages and out of the parking garages.
17 It's been a team effort. There is no single
18 entity or individual that I can think of that's
19 focused on that, but it is one of the concerns
20 that we've had.

21 DR. KIZER: Wayne, could I perhaps make
22 two comments in response to a couple of questions?

1 Central to a number of the recommendations that
2 were made was the need to design flexibility into
3 the design and in response to the question that
4 was asked here, the recognition that whatever is
5 designed and built to deal with the current
6 casualties is likely to change in 10 to 15 years
7 or the next conflict and that should be recognized
8 in how the facilities are designed so they can be
9 fairly adaptable to future needs, and that's
10 certainly the mantra in private hospital
11 construction today.

12 The other point I would make with regard
13 to filing prescriptions and being cognizant of
14 Secretary Gates's comments about the need to
15 reduce DOD health care spending, this is one
16 opportunity that is a -- opportunity. I don't
17 recall the exact numbers but I believe the DOD
18 handles about 10 percent of its prescriptions on a
19 mail-out basis in contrast to the VA where about
20 85 percent of prescriptions are done on a mail-out
21 basis. It's also perhaps one of the very few or
22 only process in health care anywhere that

1 consistently operates at a Six Sigma level of
2 performance so that that is an area perhaps to
3 keep in mind as a cost-saving strategy that also
4 increases the effectiveness of the system in
5 looking at broader use of mail order
6 prescriptions.

7 VICE ADMIRAL MATECZUN: Yes, and we are
8 fans of the VA's central mail order pharmacy
9 system. It is extraordinarily Six Sigma in those
10 operations so that we understand completely that
11 that is a road to quality. There are some
12 built-ins into the plans. There is room to expand
13 on the clinic buildings. You'll see that their
14 room has been left behind these. Part of Dr.
15 Kizer's panel's recommendations were that you have
16 to look to the future and be able to expand.
17 Remember that the BRAC required that we not build
18 any more capability than existed during the
19 baseline year so that we were capped if you will
20 at the number of beds that we've got and we
21 distributed them. However, in these clinic
22 buildings down at Fort Belvoir which is now where

1 the majority of our population is moving, down
2 south on the 95 corridor there's room to expand
3 out and there is also room to expand out the back
4 of these inpatient towers so that we can add
5 inpatient capability as well.

6 We kept that in mind when we took a look
7 at the Bethesda campus. Here this is going to be
8 built and what they're working on is a concept
9 that goes beyond this building so that if you take
10 a look at Bethesda 2040, this is 2018, then you
11 will see that it starts to flow into the rest of
12 the campus in terms of being able to increase
13 capacity if you need to. Nobody talks about
14 decreasing capacity and certainly in these large
15 complexes that seems to be the way that it's
16 going. But yes, these were great recommendations
17 from the panel and we've been happy to incorporate
18 them into our planning.

19 DR. LEDNAR: Admiral Mateczun, on behalf
20 of the Board we really appreciate first this brief
21 today, but I think we could all see the complexity
22 of this project and it wouldn't come together

1 without extraordinary leadership and we really
2 appreciate what you've done to make this all
3 happen. Care doesn't stop. You are flying an
4 airplane and fixing it as you go and we really
5 appreciate the leadership that you've brought not
6 just in terms of the medical aspects of this but
7 you've got a lot of work with Health Affairs, with
8 Congress, with communities like Montgomery County
9 and a lot of balls in the air. So from all of us
10 and our wounded warriors, thank you for your
11 leadership. The Board continues to stay available
12 to you in any way that you would find helpful.
13 Thank you.

14 VICE ADMIRAL MATECZUN: Thank you.

15 DR. LEDNAR: Our next speaker is Colonel
16 Thomas Baker. Colonel Baker serves as the interim
17 director of the Joint Pathology Center. Colonel
18 Baker is board certified in anatomic and clinical
19 pathology with subspecialty expertise in renal and
20 transplant pathology. Period to his selection as
21 interim director, Colonel Baker served as chief of
22 the Integrated Department of Pathology at Walter

1 Reed Army Medical Center and the National Naval
2 Medical Center and was associate chair of
3 pathology at the Uniformed Services University of
4 the Health Sciences. In addition, Colonel Baker
5 currently serves as faculty member of the National
6 Capital Region Pathology Residency Program and
7 Nephrology Fellowship Program. Colonel Baker
8 today will provide a progress report on the Joint
9 Pathology Center. Colonel Baker's briefing slides
10 may be found in our binders under Tab 9. Colonel
11 Baker, thank you for joining us.

12 COLONEL BAKER: Thank you, sir. I
13 appreciate it and I appreciate the opportunity to
14 update the Defense Health Board. If you'll look
15 at the slides, what you'll see is this is a little
16 bit different than the briefing we had last time
17 so that hopefully I'm assuming that there's a
18 little bit of baseline knowledge and my apologies
19 if I lose anybody. I'm happy to backtrack and
20 explain things.

21 A little bit of background. We
22 discussed this at the March meeting. As of BRAC

1 2005, the Armed Forces Institute of Pathology must
2 be disestablished by September 2011. The National
3 Defense Authorization Act of 2008, Section 722,
4 outlines the establishment of the Joint Pathology
5 Center within DOD in a manner that's consistent
6 with BRAC law. The components of the Joint
7 Pathology Center as outlined in law is that it
8 will serve as the Pathology Federal Reference
9 Center, the reference center for the federal
10 government, will provide pathology consultation,
11 education including continuing medical education
12 and graduate medical education, pathology research
13 and then the Tissue Repository that's currently
14 part of the Armed Forces Institute of Pathology,
15 maintenance modernization and utilization of the
16 repository. The mission was delegated officially
17 to the Department of Defense in April 2009 and
18 delegated to the Joint Task Force National Capital
19 Region Medical in December 2009 so that we've had
20 the mission for about 11 months.

21 In anticipation of delegation, we lean
22 forward in the foxhole. The JTF CapMed put

1 together an implementation team in summer 2009
2 that includes the members who are listed from the
3 three services, from the VA, USUHS, the Armed
4 Forces Institute of Pathology as well as JTF Army
5 Executive Agent and Health Affairs. Our goal then
6 was to take the original CONOPs that I briefed
7 back in 2008 and perform a gap analysis on it and
8 identify the things that were missing in our
9 initial plan. We did a very thorough gap analysis
10 and from that developed the detailed concept of
11 operations and drafted an establishment plan.
12 With the official delegation of the mission in
13 December 2009 we changed the team to a transition
14 team. The activities were we were developing an
15 operation plan, assisting in personnel, equipment,
16 budget facility issues and this is still an
17 ongoing process as members of this team are still
18 involved in the establishment of the Joint
19 Pathology Center.

20 The Joint Pathology Center Office of the
21 Director was established on October 1 so that we
22 have an official presence now. As I go through

1 we'll talk a little bit about the differences from
2 the previous presentation that I did in March.
3 This slide you saw at the last briefing outlines
4 the five pillars of the Joint Pathology Center.
5 Four of them you'll recognize as being from NDAA
6 2008 that's a part of the law, pathology
7 consultation, maintenance utilization and
8 modernization of the Tissue Repository, pathology
9 research and pathology education. The last piece
10 there is strategic partnerships and we consider
11 this a critical pillar or critical piece to the
12 Joint Pathology Center as we move forward and as
13 we mature as an organization in developing those.
14 Not only will it argument and enhance our
15 capabilities, but it really provides a force
16 multiplier for the Joint Pathology Center.

17 There were some changes from the
18 previous presentation that I made in March of this
19 year. What we had discussed back then was that we
20 were going to phase in the mission of the Joint
21 Pathology Center in coordination with the AFIP as
22 they just established and we were going to phase

1 it in over a 6-month period. After working this
2 through in careful coordination with the Armed
3 Forces Institute of Pathology we decided that
4 probably the best approach would be to transfer
5 this on one day and that would be April 1, 2011.
6 The AFIP will continue their mission of providing
7 consultation, education, research and repository
8 services up until April 1 and we'll assume it on
9 that date. Obviously as we get down to the work
10 of doing this there is going to be a little bit of
11 overlap, but that's the official date for the
12 transfer of the mission from the AFIP to the JPC.
13 Even after establishment, the AFIP will continue
14 to support the JPC through summer 2011 and we've
15 worked out a lot of those details and will be
16 working on more of those details, but they will be
17 supporting us through the establishment. Our goal
18 is full operating capability by September 2011.
19 As I said, the Office of the Director was
20 established in October 2010 and on October 1, 60
21 people were transferred to the Joint Pathology
22 Center from the AFIP as a part of the transfer

1 function that occurred and 45 of those we detailed
2 back to the AFIP to continue their important
3 mission since we won't assume the mission until
4 April 1.

5 As for the Office of the Director, as I
6 said, that was officially established on October
7 1. It consists of 15 personnel that were
8 transferred over. We're in the process of hiring
9 five additional personnel as well. For the most
10 part this is information technology, quality,
11 administrative folks, histotechs as well as a
12 laboratory manager. What we're doing right now
13 with the Office of the Director is developing the
14 administrative structure for the JPC. This
15 includes how do you handle personnel issues, how
16 do you deal with contracts, how do you deal with
17 budget, all the things that you need that are
18 running in the background of a successful
19 organization. As we talked about in the past, one
20 of the key elements of the Joint Pathology Center
21 is the quality management plan and having an
22 overarching quality management plan to allow the

1 JPC to function. We do have three quality folks
2 on board, three positions, and we're going to be
3 developing their quality plan so that we can apply
4 for CAP accreditation.

5 Other things include we're finalizing a
6 lot of the transferring of equipment from the
7 AFIP. Somebody brought up in the past that why
8 would you want all the equipment? The fact is if
9 you look at the equipment at the AFIP, it's
10 state-of-the-art. It's new, it's state-of-the-
11 art, it's the equipment we need and purchasing new
12 equipment, there is really no added benefit to
13 doing that. We're being selective but it turns
14 out to be about 500-plus pieces of equipment that
15 we're going to be transferring over from the AFIP.
16 In addition to that we're also purchasing the
17 equipment that perhaps is not available at the
18 AFIP or that we do want to modernize. We're also
19 implementing contracts. There are contracts that
20 are currently at the AFIP that we're transferring
21 over. Other ones include new contracts that we
22 have that we're implementing for the JPC.

1 Information technology is one of the key
2 pieces of the Joint Pathology Center and one of
3 the key pieces that needs to be in place for us to
4 assume the mission on April 1. We have five IT
5 folks who came over as a result of transfer
6 function from the AFIP and the big project that
7 they're working on, there are a couple of big
8 projects, but the biggest project that they're
9 working on is taking the AFIP laboratory
10 information system called PIMS and converting that
11 to the joint pathology version of PIMS or what we
12 call JPIMS. This is applying the JPC business
13 rules to that model and modifying it so that it
14 can function as a part of the JPC. A piece of
15 that that goes with that is at the bottom there
16 where I've listed obtaining DIACAPS approval.
17 That's security approval and it's a rather lengthy
18 process for security approval for this information
19 system to be on the network so that that is one of
20 the pieces that we're looking at.

21 The other big piece that we're looking
22 at is developing a JPC website. One of the pieces

1 of that is, number one, you have the JPC website,
2 the JPC presence with the information and contact
3 information and all that, but there are also
4 several other things that we're going to have as a
5 part of the JPC website. The third piece there is
6 the education module and we'll talk about that as
7 a little bit. The other two include we want to do
8 online specimen accessioning and we're already
9 working on that in how to move that forward as
10 well as how do you get your consultative reports
11 to your customers. You can fax them and you can
12 do things like that, but what we'd like to do is
13 have consultative reports available to the
14 providers who refer cases to us for consultation
15 and have them online so that they can view them
16 online.

17 The Office of the Director is also
18 developing the budget requirements for fiscal year
19 2012 and beyond. We're working very closely with
20 the Resource Management shop at the Joint Task
21 Force to do this. We're also working on our
22 strategic communication, that is, working with our

1 federal stakeholders, our customers to ensure a
2 smooth transition of clinical services from the
3 AFIP to the JPC. There was also a small blurb in
4 CAP's "Statline" talking about the Joint Pathology
5 Center as well as an article in CAP Today, which
6 in more detail describes what the Joint Pathology
7 Center is. These are not only for the federal
8 stakeholders that we're talking about but also for
9 the pathology community in general.

10 The pathology consultative service. In
11 terms of personnel, 10 AFIP pathologists
12 transferred to the Joint Pathology Center on
13 October 1 and they were detailed back to the AFIP
14 so that they're still working at the AFIP and will
15 do so until the mission transfers to the Joint
16 Pathology Center. We're bringing two additional
17 subspecialty pathologists on board in December as
18 the result of a transfer from the VA. We have an
19 active-duty oral pathologist coming to the Joint
20 Pathology Center in November. We have just
21 completed hiring actions on four pathologists and
22 we have recruitment actions pending for multiple

1 other pathology positions. We have about nine
2 recruitment actions going at this point.

3 One of the issues I think that was
4 brought up at the last Defense Health Board was
5 difficulty in recruiting. We've had absolutely no
6 difficulty in recruiting. I have lots of
7 applicants for the positions, very, very well-
8 qualified applicants for the positions. With
9 maybe one or two exceptions I think we're going to
10 have no problem in filling all the positions for
11 the pathologists at the JPC. The other thing that
12 we're doing as a part of consultative services is
13 developing the process of specimen accessioning,
14 specimen control and courier system, recognizing
15 that that's a critical piece to the Joint
16 Pathology Center working well. We're working on
17 that and we should have that finalized in the next
18 month to month and a half.

19 In terms of histology as we discussed
20 before, the histology lab for the nonpathologists
21 who will cut the slides, do the special stains for
22 the slides and things like that, part of our plan

1 was to have a histology lab for the entire joint
2 area of operation for the JTF that would serve
3 Fort Belvoir, the new Walter Reed as well as JPC.
4 We're moving forward with that. Understanding
5 that there are concerns and risks to this
6 obviously since all the pathology will be done at
7 one place and will be separate from the Joint
8 Pathology Center, there is some risk and we looked
9 at what do we need to do to mitigate that risk.
10 Number one, having a robust courier system in
11 place and having good communication between the
12 two campuses is one piece so we're looking at how
13 to do that.

14 I think the benefits of doing all
15 histology in one location, number one, we can
16 focus on high quality and good turnaround time.
17 We're looking at a 24/6 operation with expected
18 turnaround time for all cases to be next shift.
19 As I tell pathologists, you order special stains
20 at 4:00 at night, you go home and they're on your
21 desk the next morning so that we have that piece
22 in place as well. We're also focusing on

1 automation of our special stains in our
2 histochemistry and our folks are working very
3 closely with the JPC pathologists, the ones at the
4 AFIP and others, to help us to ensure that the
5 quality of the stains that we're automating are
6 acceptable. We want the highest quality so that
7 we're involving the pathologists in helping us to
8 determine that what we're doing is the right thing
9 to do.

10 Molecular laboratories. We had talked a
11 little bit about molecular laboratory capabilities
12 that are going to assume AFIP's functioning
13 molecular laboratory en bloc block moving it over
14 to the Joint Pathology Center. It will be in
15 Building 17 that Admiral Mateczun had pointed out
16 on one of his slides. It won't be available until
17 August 2011, so the AFIP will continue that
18 function in support of the JPC until we can assume
19 that in August 2011.

20 The Environmental/Biophysical Toxicology
21 Lab. This is the depleted uranium and embedded
22 fragment lab. We're looking at several sites.

1 We're very aggressively pursuing opportunities for
2 locations for this laboratory. We have some good
3 prospects that should come to fruition hopefully
4 in the next month or so. Until we assume we
5 assume that function at the Joint Pathology
6 Center, the AFIP will be continuing to provide
7 that function for the JPC and for the federal
8 government.

9 There are two pieces to education.
10 Number one is continuing medical education and
11 number two is graduate medical education. Our
12 continuing medical education focus is online and
13 that's what we're putting into place using the Ask
14 AFIP education module. When you go on their
15 website you'll see that there is a pretty robust
16 educational module called Ask AFIP. We're going
17 to use that as the backbone for our JPC online
18 offerings with webinars, online lectures as well
19 as digitized slide repositories for continuing
20 medical education credit. What this allows us to
21 do is it opens up the aperture in terms of our end
22 users being able to use it and whether it's at a

1 one-person facility or somebody who's deployed or
2 whatever, it allows greater participation in the
3 educational process.

4 The second thing is that by doing online
5 offerings this allows us to be much more
6 responsive to our customers in terms of their
7 needs for educational opportunities. Although we
8 won't be providing live courses, we of course will
9 support live courses that are brought to us,
10 appropriately vetted but brought to us and there
11 are a couple of them that are still working their
12 way through the system that we anticipate
13 supporting once we see their final proposal on
14 this. Continuing medical educational credit for
15 our online presence will be provided by USUHS, by
16 the university. At least initially that's going
17 to be the extent of their involvement in our
18 continuing medical education but as the JPC
19 matures we see a significant opportunity for
20 working across that organization to improve the
21 offerings for continuing medical education.

22 In terms of graduate medical education,

1 we'll be offering fellowship rotations as well as
2 residency rotations for federal government
3 fellowships and residencies and we're putting MOUs
4 in place to allow this to happen with federal
5 facilities right now. We anticipate being able to
6 accept residents on rotation in July 2011 so we
7 have about a 3-month period from the time that we
8 start the mission on April 1 to July 1 to allow us
9 to be able to get up to speed to appropriately
10 train residents. The other thing that we're
11 supporting is the Navy Oral Pathology Residency
12 Program. This is a 3-year residency program and
13 the AFIP currently does one full year of that
14 3-year residency program and we've committed to
15 doing the same thing for the program with the
16 Joint Pathology Center so that we'll be assuming
17 that on April 1.

18 Additionally, it's not on this slide,
19 but as of course for the Veterinary Pathology
20 Residency Program that's currently at the AFIP, we
21 will be assuming that mission as well and as we
22 discuss veterinary pathology in a few slides, that

1 will be coming over a little later from this but
2 our goal is to be able to provide that residency
3 education as soon as that mission is taken by the
4 Joint Pathology Center.

5 There are two pieces to the research
6 piece here. Number one is pathologist-driven
7 research and then number two is the Tissue
8 Repository and we'll talk about opportunities with
9 the Tissue Repository I believe with the next
10 side. In terms of pathology-driven research, what
11 we're looking at is transferring up to 85 current
12 active protocols from the AFIP to the Joint
13 Pathology Center. We're not sure what the final
14 number will be. It will depend somewhat on where
15 they are in terms of research, but that's what
16 we're looking at right now.

17 The second bullet I mentioned for a
18 reason. The Comprehensive Cancer Center, and it
19 should be Cancer Center and not Cancer Treatment
20 Center, is an NCI designation and Admiral Mateczun
21 referred to this. It's an initiative at the JTF
22 to achieve NCI designation. When you look at that

1 program, one of the things that they allow is for
2 this to be done as a consortium. So we've been
3 brought that into the discussion on this and this
4 is a great opportunity from a research
5 perspective.

6 If you look at the NCI requirements for
7 Comprehensive Cancer Center designation, one of
8 the big pieces is research. It's not just
9 clinical trials. It's all the way from basic
10 science to clinical trails so that it's a whole
11 spectrum of research opportunities for that
12 designation. Looking at the Cancer Centers of
13 Excellence that are going to be a part of this,
14 UHUHS, the NCI, all the players in this consortium
15 and looking at the capabilities and the
16 opportunities that there are with all of these,
17 it's phenomenal. As this develops I see this as
18 being one of the key pieces at least initially to
19 the JPC being able to conduct pathologist-driven
20 research.

21 In the third bullet, we're working very
22 closely with the Associate Chief of Research for

1 Headquarters VA to identify opportunities for
2 collaboration and support. We've already
3 identified several potential opportunities over
4 the next couple of years that we're going to look
5 at as the JPC matures. I'll talk about the Tissue
6 Repository later.

7 As for other federal stakeholders, as
8 you'll see there is a lot of interest in the
9 Tissue Repository in utilizing that for research.
10 But the other piece is for us to develop the
11 partnerships appropriate or necessary for
12 collaborative efforts not only within the
13 Department of Defense but also with other federal
14 agencies, with the NIH and with the CDC and
15 others. The opportunities for research are not
16 going to be just in the JTF CapMed or in the new
17 Walter Reed or with UHHS. Our goal as the JPC
18 matures is to bring in the other federal
19 stakeholders and look for research opportunities.

20 The Tissue Repository is obviously a big
21 piece to the Joint Pathology Center and I have a
22 couple of things. If you go down and you look at

1 the Tissue Repository, it is a national treasure
2 in terms of what they have. It's a one-of-a-kind
3 repository of pathology specimens. You won't see
4 anything else like that in the world. I applaud
5 the AFIP for bringing the Tissue Repository to
6 this point over the last couple of decades. It's
7 a great opportunity. There are a couple of
8 questions we raised.

9 Number one, as a part of our plan early
10 on we want to open up the repository to allow it
11 to be utilized for research but how do you do it
12 in a careful and considered manner? How do you do
13 it so that it ensure sustainability of the
14 repository? And how do you do it to ensure that
15 appropriate priorities between perhaps competing
16 entities or agencies is taken into consideration?

17 It's quite a complex process if you want
18 to open this up. What we're doing is a
19 two-pronged study of the Tissue Repository. The
20 first phase of that study is we recently completed
21 a contract with the Institute of Medicine which is
22 one of the arms of the National Academy of

1 Sciences to conduct a study and inform us to help
2 make recommendations in terms of the Tissue
3 Repository. What should the mission and vision of
4 the Tissue Repository be in a way obviously that's
5 consistent with the mission and vision of the JPC?
6 Who should have access to the Tissue Repository?
7 Should it just be DOD? Should it be the federal
8 government? Should it be broader? They're going
9 to help us answer those questions.

10 What technology should be considered
11 when we look at the repository and we officially
12 stand that up for utilization? An offshoot of
13 that is what business model should the repository
14 use for research? I think a lot of these actually
15 cover the Defense Health Board's original
16 recommendations in terms of ensuring that we have
17 the right process in place to utilize the Tissue
18 Repository. The business model as I mentioned is
19 an offshoot of technology so that the technologies
20 will be a part of what drives the business model.
21 I can tell you that there are several different
22 business models that you could think of if you had

1 to think about how you would run a tissue
2 repository, but how do you do it to ensure
3 sustainability and that it's used correctly?

4 What materials should the Tissue
5 Repository store? Right now it's about 32,000
6 square feet of tissue that includes glass slides
7 and paraffin-embedded tissue blocks which are the
8 blocks that slides are cut from. There are also
9 about 500,000 wet specimens, that is, specimens in
10 formalin. There are 18 freezers' worth of frozen
11 tissue and there are a lot of documents as well,
12 radiographs and other documents. The AFIP
13 currently right now is digitizing a lot of that,
14 but in terms of as a part of the mission and
15 vision, what materials should be maintained in the
16 Tissue Repository? We've asked the IOM to help
17 inform us on that as well.

18 Then of course when you look at the
19 Tissue Repository, there are a lot of unique
20 collections. There are larger collections of
21 specific malignancies and other nonmalignant
22 diseases that you won't see anywhere else. There

1 are also unique and very rare tumors and unique
2 and very rare infectious cases that if you gave
3 over to research you wouldn't have any more in the
4 Tissue Repository. What is the balance there?
5 What do you do with those unique collections? Do
6 you not use them or do you find a way to use them
7 and allow it to be done without depleting those
8 rare collections, and we've asked the Institute of
9 Medicine also to help us with that. The Institute
10 of Medicine deliverable is June 2012, about 17
11 months.

12 The second phase of the study, as I
13 said, this is a two-pronged study, we plan on
14 overlapping this with the IOM study. This is the
15 nug work for the Tissue Repository such as
16 developing a process for utilization of material
17 in the repository. What are the regulatory
18 requirements or what is the approval process?
19 Should you have a scientific advisory board that
20 approves and so on, really getting those pieces
21 into place. Then how do we appropriately resource
22 the repository? What personnel do we need? That

1 really depends on the technologies we have in
2 place. What IT requirements do we need to fully
3 utilize the repository and appropriately utilize
4 the repository? Then as I alluded to, the
5 organizational structure to oversee the repository
6 utilization, and as we talked about earlier with
7 technologies, technologies obviously drive the
8 ability of the repository to be appropriately
9 utilized so that we have to look at that. Then
10 space requirements. What space do we need to do
11 this?

12 We anticipate 2-plus years or probably 2
13 years to complete these portions of the study.

14 During the study we'll continue to use the Tissue
15 Repository in support of the consultative mission
16 and for education. Those typically don't deplete
17 the repository so that those are sustainable.
18 Then of course we talked about the fact that there
19 are 85 active ongoing protocols coming to the
20 Joint Pathology Center potentially. A lot of
21 those are retrospective studies that rely on
22 material in the repository so that we'll continue

1 to support those. Then we are going to have 29
2 pathologists at the Joint Pathology Center, many
3 who would like to use the repository for research
4 even in that 2-year interim so we're going to do
5 that on a case-by-case basis but we want to be
6 able to support the JPC pathologists' research.
7 The bottom line with this is that opening this up
8 beyond the JPC at least initially will not occur
9 until after our studies are done and everything is
10 in place for us to do this appropriately.

11 As we talked about as the last brief on
12 veterinary pathology, the AFIP right now has a
13 Veterinary Pathology Program that's unique and
14 there's really nothing like it. In terms of
15 pathology consultation there are really no
16 veterinary pathologists that you can go to to
17 formally consult in the world so that this is a
18 unique group. In addition, they also have the
19 only Veterinary Pathology Residency Program in the
20 Department of Defense and they also are actively
21 involved in research. The veterinary pathology
22 residents are trained in part to support research

1 efforts once they graduate so that we're taking
2 that mission to the Joint Pathology Center. We
3 anticipate being able to assume that function by
4 June 1 and our limiting factor on this is space
5 available and we'll talk a little bit about space.
6 The 85-P will continue to provide this service
7 until it's transferred.

8 DR. LEDNAR: Colonel Baker, in the
9 interests of time can we ask for the remainder of
10 your material if you can draw out the highlights
11 for us and then we'll have some time for questions
12 with you?

13 COLONEL BAKER: Certainly, sir. In
14 support of stakeholders, I'll just get down to the
15 federal agencies. Obviously support of our
16 federal stakeholders is one of the key things for
17 the Joint Pathology Center and we did put out a
18 survey in the spring. We do have some responses
19 from our major stakeholders or from our federal
20 stakeholders. What we have to do with that is we
21 have to loop around and close the loop on the ones
22 that didn't respond. For example, Homeland

1 Security, the State Department, Justice and the
2 FBI, we really need to loop around and close that
3 and be able to identify what can we do to support
4 those missions. I've already started closing the
5 loop. I've already talked to the FDA on one of
6 them that's not listed and they're going to be
7 getting me a final report hopefully this month. I
8 think the bottom line here is that our
9 organization allows for sufficient flexibility to
10 address stakeholders' current and future needs as
11 we identify these things and this discussion with
12 our stakeholders is an ongoing process. It's not
13 a static process so that we'll see opportunities
14 as new things come up that our stakeholders would
15 like us to do.

16 As I said, a formal survey went to other
17 federal agencies and we received responses from a
18 portion of Health and Human Services and I've
19 listed the things from Indian Health Services and
20 then several divisions of the CDC. Then of course
21 as I said we need to loop around with other
22 federal agencies and close the loop on this so

1 that we know what type of support federal agencies
2 need. Of course, the VA has always been a big
3 part of our discussion and we have ongoing
4 discussions with them in terms of how we can
5 support them and I've listed things. There are a
6 couple of new things on there. This is like I
7 said an ongoing discussion. These are facilities
8 and nothing has changed. Our consultation service
9 will be in Building 606. The renovation is
10 complete. I know one of the concerns that was
11 brought up was pathologists being in cubicles. We
12 already have plans in place to reconfigure the
13 space for private offices so that there will be
14 private offices for all of the pathologists. The
15 Tissue Repository is in Buildings 606 and 510.
16 Building 510 is undergoing life safety renovation
17 which will be completed this next summer.
18 Veterinary pathology will be up on the Forest Glen
19 campus as well and that space is being renovated
20 and should be done by about April 2011.

21 As we talked about, histology is going
22 to be performed for the Joint Area of Operations

1 at the new Walter Reed. The new space is
2 renovated. The space is occupied right now. It's
3 6,000 square feet of very high- tech lab.
4 Molecular laboratories will be in Building 17 on
5 the Bethesda campus and renovations should be
6 completed by August 2011. Then with the depleted
7 uranium and embedded fragment laboratory we're
8 still look for space but we hope to finalize that
9 very shortly. As for our budget for Fiscal Year
10 2011, that's a mistake. It's \$10.1 million, but
11 if you include the 45 pathologists who ere
12 detailed back to the AFIP it's actually \$13.6
13 million and we're working on the fiscal year 2012
14 and beyond budgets.

15 Our way forward as we've talked about
16 before as our top priority is to ensure continuity
17 of clinical services during the establishment.
18 We're going to continue our hiring process. We've
19 been very successful so far. We'll refine and
20 submit our budget for Fiscal Year 2010, finalize
21 the requirements for DU testing, refine and
22 finalize logistical and IT requirements, continue

1 with our Strategic Communication Plan and develop
2 policies and procedures. This includes the
3 accessioning process, transferring of contracts
4 and our goal is to be CAP accredited by September
5 2011 so that we have that as our end state for the
6 Joint Pathology Center. One of the things that
7 the Defense Health Board brought up was oversight.
8 We've talked about a board of advisers being in
9 place to provide advice to the Joint Pathology
10 Center so that we need to define the function and
11 structure of the board of advisers which will be
12 made up of representatives from stakeholders and
13 then implement that plan. The other thing is to
14 select an inaugural director in summer 2011 for
15 appointment after full operating capabilities
16 after September 2011. The reason for this is that
17 you don't want to change captains in the middle of
18 the establishment here. I'll take this through
19 establishment until the inaugural director comes
20 on board.

21 Thank you. That's all I have. I
22 appreciate the opportunity to brief. Are there

1 any questions?

2 DR. LEDNAR: Thank you, Colonel Baker.

3 I'd ask Dr. Parisi, a member of the Board, if he
4 would like to first an opportunity to make any
5 comments or ask any questions. Dr. Parisi?

6 DR. PARISI: Thank you, Colonel Baker,
7 for your update. I'd like to preface my comments
8 by reasserting that the Defense Health Board is
9 committed to assisting you in designing a JPC that
10 is going to succeed, satisfy the spirit and
11 requirements of the law and continue to provide
12 excellence in consultation, research and education
13 that will advance our understanding of diseases.
14 Having said that, I feel somewhat like a broken
15 record because many of the comments I will offer
16 have been iterated before in written reports as
17 well as in public hearings and in private
18 conversations.

19 My sense is that the JPC is evolving as
20 a hospital-centric surgical pathology service with
21 little emphasis on research and education and
22 which in its current state anyway does not fulfill

1 the congressionally mandated requirements to
2 function as the reference center in pathology for
3 the federal government. If you look at pathology
4 as a field, pathology is an evolving field just
5 like everything else in medicine. Histologic
6 diagnoses already are being augmented by molecular
7 diagnostic techniques and there are more and more
8 newer techniques coming down the road. The JPC
9 really ought to embrace these new technologies and
10 be the leader in the field if indeed it's going to
11 be the Center of Excellence that has been
12 demanded.

13 I've got some specific comments
14 regarding the diagnostic services mission. I'm
15 still concerned about the appropriate staffing of
16 the JPC. Will the staff be mainly junior-level
17 people or will it consist of senior-level people?
18 Will those senior-level people be full-time or
19 part-time? Mentoring is a very important part of
20 the evolution of a pathologist and who will do
21 this mentoring? I think these are very important
22 considerations. I'm not sure what criteria are

1 being required for the hiring of new pathologists
2 or what the process in place is for that. You
3 mentioned that pathology support in the field will
4 be provided by telepathology. I think that's
5 great, but who is going to do the reading of the
6 diagnoses? Is it going to be done again by junior
7 staff or senior staff? And what kind of quality
8 assurance of policies or activities will be in
9 place to monitor that is the quality and
10 correctness of diagnoses rendered by the JPC? I
11 think the physical separation of pathologists from
12 the accessioning area, the laboratories and the
13 transcription areas is still a potential problem
14 but I understand there are some constraints
15 because of space limitations. However, I again
16 reiterate that I would encourage you to look at
17 ways to make a better marriage of those functions.

18 The laboratories being at the Walter
19 Reed campus also raises questions of
20 responsibility of the JPC pathologists for
21 efficient interpretation and performance of
22 special studies and diagnostic procedures and I'm

1 not sure who is going to direct the laboratory,
2 who is going to be in charge of specialized
3 procedures and pulling this all together may be
4 problematic since the priorities for the hospital
5 are clearly different from the subspecialty
6 priorities of the JPC. You mentioned that
7 state-of-the-art labs will be provided. I'm not
8 sure what that means? What is menu of
9 immunostains or in situ hybridization techniques
10 that will be available? Where will new procedures
11 be developed and validated as they become
12 available? Will specialized immuno-EM, scanning
13 EM and florescence microscopy be available and
14 where will these occur? Will there be wet-tissue
15 labs and where will those be located? Where will
16 the environmental pathology and toxicology labs be
17 located particularly with respect to analyses for
18 drugs, toxins, polymers and other foreign
19 materials that result in disease?

20 DR. LEDNAR: Dr. Parisi, may I make a
21 suggestion? I think the kind of detailed thoughts
22 you're having will be very useful to Colonel Baker

1 and the JPC. We're not asking, Colonel Baker, for
2 you to respond to all of these but I think it's a
3 sense of some of what Dr. Parisi and the Board
4 sees as aspects to help the JPC succeed in its
5 mission. As the Board in its position that
6 continues to be supportive to you and to the
7 department, I might offer that Dr. Parisi and
8 anyone else from the Board who is interested to be
9 available to elucidate these and discuss these and
10 be sure that you understand the thoughts behind
11 them as you consider your way ahead. Would that
12 be okay, Dr. Parisi?

13 DR. PARISI: I think there is progress
14 that's been made. I think that we have a ways to
15 go. I think the development of the Comprehensive
16 Cancer Center as you mentioned provides a real
17 opportunity, but to really provide that
18 opportunity is going to require dedicated
19 laboratory basic kind of research, the sorts of
20 things that you've already described in your
21 briefing. I have a whole list of other
22 suggestions here. I guess I had another question.

1 DR. LEDNAR: Dr. Parisi, here's a
2 thought, and that is given the really detailed
3 evaluation that you've given to this that we might
4 ask you to prepare some written notes or written
5 outline of your thoughts in completeness given the
6 spirit of time here and then we can get these to
7 Colonel Baker and to the staff of the JPC, and
8 then we'd ask if the JPC would come back and share
9 their thoughts to this listed of suggestions that
10 you would have for them from the Board. Would
11 that be an acceptable way ahead?

12 DR. PARISI: Sure.

13 DR. LEDNAR: Thank you, Dr. Parisi. Are
14 there other questions or comments? Dr. Walker?

15 DR. WALKER: Twenty-nine pathologists is
16 a lot and seems like it would be an opportunity to
17 have a lot of subspecialists, but I'd be very
18 interested in knowing what the subspecialties
19 would be and how will recruitment assure that you
20 get pathologists who are really committed to
21 advanced investigation of disease further than
22 just routinely looking at slides through a

1 microscope.

2 COLONEL BAKER: Absolutely, sir. We've
3 outlined before the subspecialties that will be in
4 the Joint Pathology Center and it really
5 encompasses the entire spectrum. I think there
6 are 11 or 12 of them. One of the things we won't
7 be having is pediatric pathology, but we're really
8 encompassing everything else. In terms of that I
9 think we do have that covered.

10 DR. LEDNAR: Dr. Silva?

11 DR. SILVA: Wayne, I've had the
12 opportunity to look Joe's shoulder and he has very
13 extensive notes there and as a Board member I'd
14 like to know what he's going to state, so I like
15 your idea to put it in writing. But when they
16 fill in the acrostic because we want to assure the
17 quality of this lab, then I think we should put it
18 on the next meeting to see what the blanks are on
19 the chart. It's very extensive, but it's a detail
20 we need to know about as in how good this lab is
21 going to be and is it going to be world class. So
22 I would ask for that review.

1 DR. LEDNAR: Yes, the Board will be
2 copied on the notes and correspondence. Dr.
3 Parisi will be preparing for the Board and will be
4 shared with the Board to Colonel Baker and the JPC
5 and then we can schedule at an upcoming meeting
6 another touch point to these points. Good
7 suggestions.

8 DR. SHAMOO: Dr. Lednar?

9 DR. LEDNAR: Dr. Shamoo?

10 DR. SHAMOO: Very, very quickly. I
11 think it would be more appropriate to have a small
12 ad hoc committee of Dr. Parisi, Dr. Silver since
13 he is knowledgeable and interested in this subject
14 and one more person and then bring a more
15 distilled report to the Board. Otherwise, I think
16 we are having one individual speaking for the
17 Board and we don't have a clue what the content is
18 and that to me would be much more in line with the
19 structure of the Board.

20 DR. LEDNAR: I would say yes and yes. I
21 would say that probably the most useful way to
22 understand these points is in a small group

1 discussion with members of the Board and with
2 Colonel Baker and his staff and to process that
3 and then as the department makes decision on the
4 basis of that input to bring a summary of some of
5 those key points back as an agenda item to the
6 Board by Colonel Baker. Dr. Parkinson?

7 DR. PARKINSON: Just a clarification.
8 Is the National Capital Region seeking to be a
9 designated NCI cancer center, the NCR, or is that
10 still being debated?

11 VICE ADMIRAL MATECZUN: We're engaged in
12 discussions with Dr. Varmus on that. The end
13 result of being an NCI-designated cancer center is
14 grants. We don't need the grants necessarily and
15 so what we're probably going to do is to work
16 through the attributes of a Comprehensive Cancer
17 Center, not necessarily apply for the grants and
18 he'll have to make a decision about whether or not
19 that would be an NCI designation or whether we're
20 going to enter into a partnership with the NCI
21 itself.

22 DR. PARKINSON: Thank you, sir. The

1 reason I asked that is that again whether or not
2 that is an essential attribute of so-called world
3 class to Dr. Kizer's work or not, it certainly is
4 a brand and a standard that we know. As for the
5 emerging explosive change to medical practice from
6 genomics and proteomics and all of these things
7 which I hopefully will see in the IOM report, I
8 don't know if there's any possibility that Dr.
9 Erdtmann without violating IOM processes could
10 arrange for a subset of IOM staff to meet with the
11 DHB in advance of the report release or something.
12 Because I think that certainly world class in the
13 context of all the money we're putting into brick
14 and mortar should mean the capabilities are
15 absolutely cutting edge as a national resource and
16 I would hate to see the slip between the vision
17 and the practicality. It's not necessarily
18 pathology with all due respect to this discussion.
19 It really is the glue, the culture, the transition
20 processes, the art indeed of patient care and we
21 need stay in touch with all of that somehow. I'm
22 delighted that the IOM report is moving forward

1 and if there's a way that we might even at least
2 see a little bit of that of work with the IOM
3 committee it might be useful as well in the sense
4 of true federal collaboration.

5 DR. LEDNAR: Perhaps we can pursue what
6 is possible within the bounds of the IOM process
7 or not. We can do that offline. In the interests
8 of time what I'm going to ask is we adjourn this
9 discussion. I'd like to thank Colonel Baker for
10 your brief and your update.

11 COLONEL BAKER: Thank you, sir.

12 DR. LEDNAR: An image that I'm having in
13 my mind is the GPC is about to take the active
14 runway. You're going to begin your takeoff roll
15 and it's less than 12 months from now that you'll
16 be standing up and fully operational. Again the
17 Board stands committed and ready to be helpful to
18 you for success on the mission as Congress has
19 charged. So thank you.

20 COLONEL BAKER: I appreciate it and I
21 appreciate the input from the Board. Thank you.

22 DR. LEDNAR: We're going to take a

1 15-minute break.

2 (Recess)

3 DR. LEDNAR: I'd like to reconvene our
4 meeting. We are going into the last segment of
5 today's Defense Health Board meeting and what we
6 are about to do is something that the Board in the
7 past has found very, very useful, and that's to
8 have short report-backs from the service liaisons
9 to the Defense Health Board sharing with us some
10 of the health issues that they find as priority
11 from their service perspective and their service
12 point of view.

13 We will have short briefings by Colonel
14 Bob Mott for the Army, Lieutenant Phil Gould from
15 the Air Force and Captain Neal Naito from the
16 Navy. At our next meeting we will also hear
17 similar kinds of briefs from the Coast Guard and
18 from the U.S. Public Health Service and we intend
19 to rotate through our meetings going forward in
20 terms of updates. Of course, if the services at
21 any time in between have issues that they would
22 like to bring up, those through the right channels

1 can be brought to the Board. Dr. Butler?

2 DR. BUTLER: Wayne, just a quick
3 suggestion. It would be great to add the U.S.
4 Special Operations Command to that. They are
5 really a separate entity and have their own
6 four-star and a different set of problems.

7 DR. LEDNAR: That's a great suggestion.
8 Thanks, Frank. We can add that into the cycle.
9 With that I'll ask Colonel Mott if you'd begin.
10 Thank you, please.

11 COLONEL MOTT: I certainly appreciate
12 the opportunity to speak today. I've been coming
13 to what was the AFEB since 1993, so almost 20
14 years ago. It's been a real privilege to serve as
15 liaison in the last couple of years and it's
16 really interesting to see how the Board has
17 evolved. It's certainly expanded my horizons.
18 I'm a preventive medicine physician and when we
19 first got the request to speak we kicked it up the
20 chain of command to see what the issues were and a
21 lot of the issues have already been addressed or
22 are being addressed by the Board, suicides,

1 traumatic brain injury and all these.
2 Unfortunately they left it up to me to select the
3 topic, so like my throwback uniform today I
4 decided to go back to the AFEB days and talk about
5 some current thinking on tuberculosis. There has
6 been a fair amount of activity lately and a fair
7 amount of discussion and we decided it would be a
8 nice idea to you up to date on some of the
9 thinking.

10 I do want to point out that this is an
11 update. It's really not a formal question to the
12 Board. If we get to that point we'll ask that.
13 One of the reasons that we decided to talk about
14 this is Lieutenant Colonel Jamie Mancuso has been
15 doing a DRPH thesis on tuberculosis so I'd like to
16 whet your appetite and maybe get him to come in to
17 one of the Infectious Disease Subcommittee
18 meetings to give you an update on his work. Here
19 are some of the other information sources.
20 Information for this brief was taken from Captain
21 Jerry Mazurek. He's at CDC's Division of
22 Tuberculosis.

1 The reason this has been brought up is
2 the CDC in June of this year released some
3 guidelines on the use of interferon gamma release
4 assays or IGRAs. There was also a fairly detailed
5 session at the Army Force Health Protection
6 Conference in Phoenix this year that talked about
7 a lot of these issues. They talked about IGRAs,
8 talked a little bit about post-appointment TB
9 screening questions and a discussion of
10 appropriate screening approaches which I'll get
11 into in a little bit. Then last month Lieutenant
12 Colonel Mancuso did his DRPF defense and then we
13 had a JPM meeting, a Joint Preventive Medicine
14 Policy Group meeting just last week with a lot of
15 the liaisons in attendance to talk about a lot of
16 these issues.

17 To emphasize that these are not
18 questions to the Board, I thought it would be
19 better to say ponderings. This is thinking within
20 our group, the Subcommittee on Preventive
21 Medicine, infectious disease and lab communities.
22 One question we've been getting since the IGRAs

1 have come out from our folks out in the field is
2 should we start moving away from a tuberculin skin
3 test toward the IGRA test? I wanted to get a
4 little bit into what these tests are in case the
5 Board hasn't heard about this but I'm sure a lot
6 of you have. There are currently four
7 FDA-approved IGRAs. QuantiFERON-TB started off
8 back in 2001 although that's not currently
9 available; QuantiFERON-TB Gold in 2005,
10 QuantiFERON-TB Gold In Tube in 2007 and the T-spot
11 that was approved in 2008. You can think of IGRAs
12 as a skin test in a test tube. It's measuring
13 similar things to what you have in vivo in the
14 body but it's going it in a test tube. It
15 measures interferon gamma released from
16 lymphocytes in whole blood samples so that it is a
17 blood test. It is a little bit more specific. It
18 uses antigens specific to MTB so it does not have
19 as many issues as the tuberculin skin test with
20 nontuberculous microbacteria in BCG strains. I
21 did want to point out that I don't like the NTM
22 terminology or acronym. It used to be called

1 microbacteria rather than TB which is MOTTs so
2 that it would be in some infectious disease
3 textbooks.

4 It has sensitivity similar to the
5 tuberculin skin test. Specificity is one of its
6 strengths since it does not have the antigens from
7 the nontuberculous bacteria in the BCG strains
8 with a greater than 99 percent specificity in
9 subjects who have low risk for TB -- they're 89 to
10 99.6 percent. So if you compare it to TST using
11 the 15- millimeter cut-off it's similar
12 specificity. If you go down to the 10-millimeter
13 cut-off it may be more specific than the
14 tuberculin skin test especially after BCG vaccine
15 or with nontuberculous disease. A lot of people
16 think that you have a blood test and it's easy,
17 but it's really not a panacea. There are a number
18 of steps in the test. I think it was 77. It was
19 pretty dramatic the number of things you'd have to
20 do to get a result of this test so it's a lot more
21 complex than just doing a PPD. It's very lab
22 intensive unless you automate it and the Air Force

1 has been doing a lot of work trying to get
2 robotics to do this test and have had some success
3 doing that.

4 It is more costly. Estimates by Dr.
5 Mazurek are \$86 versus \$18 for the TST and those
6 are Medicare data. This is a cartoon. The top
7 right is the interferon gamma being released in
8 the skin to give you the classic wheel for PPD,
9 and then the bottom one is the cells in the tube
10 releasing the interferon gamma and that's what's
11 picked up by the test. Considerations that we're
12 thinking about, essentially IGRAs and TSTs, are
13 both FDA-approved. They're both fine tests with
14 their limitations. The nice thing about the IGRAs
15 is they only require one patient visit. They come
16 in and get the blood test and then it's resolved
17 like any other test, whereas with TST you have to
18 come back within a time-specified period which is
19 a pain in the neck. For anybody who's been in
20 basic training you have to bring the folks back to
21 get it read. Again, the IGRAs cost more and
22 certainly are not a panacea. There is a lot of

1 variability within those steps. One of the issues
2 is volume in the tubes that has to be very
3 specific. There is a fair amount of variability
4 during the blood into those tubes. There are
5 issues with altitude. If you try to draw it in
6 Denver it's going to be a lot different than if
7 you draw it out here in Washington, D.C.

8 Our current approach at least in the
9 Army is to allow the use of either the tuberculin
10 skin test or the IGRA, but even in policy we've
11 pointed out some of the nuances and some of the
12 difficulties with the tests so that it shouldn't
13 be just one person making the decision to do it.
14 It really should be a decision with the command
15 group, the lab, clinicians, Public Health folks
16 and logisticians. We've had a few MTFs. Tripler
17 is doing it, but it hasn't been adopted quite as
18 quickly as I thought it would be to be honest with
19 you. Some of the other bit issues that we
20 continue to struggle with is should we move toward
21 more targeted TB testing in accessions and during
22 predeployment periods.

1 This is a slide from Dr. Mancuso's DRPH
2 defense. What I want to point out here is you
3 have active TB in the U.S. population showing a
4 fairly steady decline. When I did my MPH up at
5 Johns Hopkins it was right about here. We had
6 that little hockey stick phenomenon that had a lot
7 of people concerned, but since then it's sort of
8 trending down again. I also have active TB in the
9 Navy or the triangles here again trending down.
10 Then if you look at TST reactors, it's turning
11 down but then coming back up. It's possibly
12 because of nontuberculous microbacterium exposure,
13 but I points out the fact that even with
14 prevalence decreasing, we're having increases in
15 TST positivity so that's a little bit of a
16 concern.

17 Targeted testing has been recommended by
18 the CDC. This is a quote from the MWR in 2000, "A
19 targeted testing program should be conducted only
20 among groups at high risk and discouraged in those
21 at low risk." There are some high-risk
22 populations that have been pretty well described,

1 but of note, the U.S. military is not really
2 considered high risk and even though we do deploy
3 to areas that have high incidence of TB, in
4 general we're not considered a high-risk
5 population. Current testing. We currently to all
6 accessions and this is all services. We do all
7 predeployments. We have moved to targeted testing
8 for postdeployment although the question that
9 we're using to decide whether to test somebody or
10 not has not been all that successful so that those
11 need to be tweaked a little bit. Then high risk.
12 If you do have a contact with an active TB case if
13 you're a health care worker who's serving in a
14 high-risk clinic or if you're working at a prison
15 and those kinds of things, we still recommending
16 testing for that.

17 Should we move toward targeted testing
18 and accessions during predeployment? One of the
19 major considerations is is it appropriate to
20 screen at a low- prevalence population. We're
21 going to have a number of false positives and it's
22 not like you're going to have a week of therapy.

1 These are folks are signing up for 9 months of
2 INH. Then the question is is it possible to
3 develop a targeted testing approach for accessions
4 in particular and also predeployment?

5 Another consideration is if we move to a
6 questionnaire-based program, we've had issues with
7 postdeployment, is it possible to develop a
8 questionnaire and have that serve as a proxy for a
9 negative-screening test during accession or basic
10 training? Then ultimately if we do go to a much
11 more targeted approach is that going to lead to an
12 increase in active TB cases?

13 There was also some discussion last week
14 about whether we should move away from doing TB
15 questionnaires on the postdeployment health
16 assessment or the postdeployment health
17 reassessments. Then instead of doing that, add it
18 to the periodic health assessment which we're
19 doing annually. The thought there would be when
20 you redeploy there's a period anyway that you wait
21 to get that TB test unless you have a known
22 exposure to an active case perhaps. Does it make

1 more sense to put it on the PDHA where you can
2 spend more time with the provider. Having come
3 back from Iraq in June, I can tell you the PDHA is
4 a very quick event. People don't want to answer
5 yes to very many things. They just want to get
6 through and get out. So I think moving it to the
7 PDHA makes some sense.

8 One consideration is maybe you may not
9 want to do this with the National Guard or the
10 Reserves if we're having issues with their PDHA if
11 it's not going to be as rapidly as we do annually
12 in the active component. Another consideration is
13 there may be a longer timeframe between when you
14 redeploy and when you get your PDHA. It should be
15 less than a year for some people and if you're
16 even deployed for 6 months it should be within
17 that 6-month period but it's going to be longer
18 than 90 to 120 days probably. Will that delay
19 cause somebody to potentially activate and get
20 active disease?

21 A real quick rundown. There are reports
22 of active TB cases by service from 2005 to 2010.

1 One thing to note is there's really not a whole
2 lot of active disease out there. In fact, the
3 Coast Guard was doing really well up until 2010.
4 I'm not sure what happened there, Erica. You guys
5 are slipping. We did have a blip in 2009, again
6 very, very small numbers for this population so
7 it's probably not statistically significant.

8 As far as the way ahead for us, we're
9 going to continue to look at courses of action for
10 doing a screening questionnaire. We're going to
11 look at those active cases and try to better
12 characterize what the risk factors are. Was it
13 truly deployment associated or was it foreign-born
14 people who would have activated anyway? I do
15 think it would be a good idea to have Dr. Mancuso
16 and the Air Force folks who have done a look at
17 the IGRAs to come to the Infectious Disease
18 Subcommittee and give you an update.

19 There's really a lot of nice analysis
20 that's been doing over the last couple of years.
21 If you have time to get that on the agenda, I
22 think it would be very useful even in the absence

1 of a formal question, although if we get it
2 through me may ask a question about targeted
3 testing and accessions and for predeployment.
4 That's the last bullet and go up through our
5 leadership either on the Army side or as a joint
6 community to ask some more specific questions to
7 the Board. That's all I have.

8 DR. LEDNAR: Thank you, Colonel Mott.
9 We have time for some questions. Dr. Poland?

10 DR. POLAND: Thanks, Colonel Mott. In
11 fact, your briefing once again proves the value of
12 doing what we're reinstating, so thank you. We'd
13 welcome that discourse with the ID subcommittee.
14 One quick question. Do you happen to know if any
15 of the cases were MDR TB or XDR TB?

16 COLONEL MOTT: I do not. I'm sure that
17 we would have heard about that. I don't remember
18 that happening either.

19 DR. POLAND: Olivera, you can add this
20 to our list.

21 LIEUTENANT COLONEL GOULD: My only other
22 comment related to that is that most of those

1 cases while they may have deployed they have in
2 their past one of the typical screening questions
3 positives such as they were foreign born or they
4 have a first-degree relative who was foreign born
5 from a country of high prevalence.

6 DR. LEDNAR: Dr. Kaplan?

7 DR. KAPLAN: In the counts in that table
8 that you have with the counts, you don't have
9 denominators. Is there any great difference in
10 rates among services?

11 COLONEL MOTT: I think the Army until
12 recently has been fairly stable as far as rates
13 and I think the other services are similar.

14 DR. KAPLAN: The total number in the
15 number of cases would be different because each
16 service has a different total number, and my
17 question is by just seeing the numbers suggests
18 there are not many, but you wonder if there's any
19 difference between them if you calculate rates.

20 COLONEL MOTT: I think we'll do that.
21 This is just a quick poll from our meeting that we
22 had last Wednesday so that we didn't have a chance

1 to do rates. It's a quick snapshot to give us the
2 burden of disease overall to see how many cases we
3 have, but that's certainly easily done.

4 DR. KAPLAN: Yes, it shouldn't be hard
5 to do. Thank you.

6 DR. LEDNAR: Dr. Walker?

7 DR. WALKER: Could you tell me how
8 foreign-born service members with a positive test
9 and history of BCG vaccination is managed?

10 COLONEL MOTT: Did you ask how many?

11 DR. WALKER: How are they managed if
12 they've got a positive test and they tell you had
13 a BCG vaccination. How do you manage these
14 individuals?

15 COLONEL MOTT: With the PPG or the PPD.
16 I'm sorry.

17 DR. WALKER: Do you treat them for 9
18 months with INH or not?

19 COLONEL MOTT: If they're above 15
20 millimeters.

21 DR. LEDNAR: Dr. Parkinson?

22 DR. PARKINSON: Thank you, Bob. I think

1 that was a good update. I too way back when
2 looked at the epidemiology of this and it hasn't
3 changed in 20-plus years that foreign born is a
4 risk. What I think in a time of more and more
5 demands on basic training and what we do, if you
6 do an approach or an analysis of this it shouldn't
7 be just PPD versus full force versus targeted or
8 the new assay full force versus targeted. It
9 might also be in the context of what is blood
10 drawn for in general for all new recruits and
11 could you piggyback this draw on something else
12 and do a true cost-effectiveness analysis in terms
13 of direct and indirect costs in terms of training
14 time and the second visit. That's a way an
15 employer increasing would look at instituting a
16 corporate fitness program with my downtime because
17 the world has changed a lot.

18 COLONEL MOTT: Absolutely. Dr. Mancuso
19 did a cost-effectiveness analysis as part of his
20 thesis. One thing that the Air Force has looked
21 at is drawing into a heparin tube instead of doing
22 it in each of the three QuantiFERON Gold In Tube

1 test which does not really impact the results of
2 the test that much, just pop on another Vacutainer
3 tube, putting it into smaller tubes in the lab,
4 but again there's a little bit of a manpower issue
5 there. I think Jamie did take into consideration
6 the time it takes to put on the TST, bring it back
7 and read it and those kinds of issues.

8 DR. LEDNAR: Dr. Kaplan?

9 DR. KAPLAN: One more question. Do you
10 have any data for dependents?

11 COLONEL MOTT: I do not. Data on how
12 many LTBI positives we have, it's very hard to
13 capture. That's one nice thing about the IGRA
14 test is that you do have a lab result which is
15 queriable so that it makes it a little bit easier
16 to define what that LTBI positive population is.

17 DR. KAPLAN: Thank you.

18 DR. LEDNAR: If I can ask while the
19 CDC's overall assessment is the military is not a
20 high-risk group when we think of testing, I recall
21 in some of our operational briefs that have been
22 given to the Defense Health Board there have been

1 humanitarian operations and there has been
2 military support offered into parts of the world
3 where tuberculosis is prevalent. I think this is
4 a story of low frequency but high potential
5 consequence particularly as we get MDR and XDR so
6 that when we think about some of these new
7 technologies it will be useful to know how some of
8 these testing technologies perform across the
9 treatment- resistance patterns of these organisms
10 as they change. It's a pretty complex area but
11 clearly an important one.

12 COLONEL MOTT: We've done TSTs for my
13 whole career and it's hard to back off of that and
14 not do them suddenly. I think what would make me
15 more comfortable is that we do have very good
16 surveillance in place and we have teams that can
17 go out and investigate active cases. I know the
18 Navy is a lot more reluctant to perhaps try this
19 than we may be because of the tight experience on
20 ships. There is a lot that goes into it but
21 having deployed and gone on humanitarian
22 operations, the exposure is really not that high

1 when you're in a deployed setting especially in
2 the current environment where you're on the fob.
3 Even people who are out patrolling don't
4 necessarily have that close contact that you would
5 think for a contact investigation. It's certainly
6 not zero risk, but I'm not sure it's as high risk
7 as you might think.

8 DR. LEDNAR: Dr. Ennis?

9 DR. ENNIS: I don't know this
10 literature. It would seem to me one thing that
11 might of interest since the sensitivity of the
12 assay is similar to the skin test and the
13 specificity is much higher, has it been done
14 already by some group used as a secondary test,
15 after a positive skin test do the IGRA and if it's
16 negative don't necessarily put somebody on an INH
17 for 9 months?

18 COLONEL MOTT: In fact, the current MMWR
19 goes into many different scenarios about how to
20 use the test and currently they are not
21 recommending serial testing although some of the
22 infectious disease physicians who were at our

1 meeting last week said that if you have a person
2 with a positive skin test who really does not have
3 any risk factors and you don't really believe the
4 test or you want to convince them that if they
5 truly are positive they need to take that 9 months
6 of INH then they'll go ahead and get the IGRA.
7 But in general the CDC is not recommending serial
8 testing with TST followed by an IGRA test.

9 DR. LEDNAR: What we'll do is we'll
10 conclude this brief. Thank you for bringing this
11 topic to use and the Infectious Disease
12 Subcommittee looks forward to an opportunity to
13 hear some more.

14 COLONEL MOTT: Thank you.

15 DR. LEDNAR: Thank you, Colonel Mott.
16 Our next speaker is Lieutenant Colonel Phil Gould.
17 Colonel Gould serves as chief of preventive
18 medicine operations at the Air Force Medical
19 Support Agency Office of the Air Force Surgeon
20 General where his principal focus is immunization
21 policy development. We look forward, Colonel
22 Gould, to hear your brief, please.

1 LIEUTENANT COLONEL GOULD: Thank you. I
2 realize that this is a weighty topic and I don't
3 really wish to add additional pounds to the
4 Defense Health Board in terms of the number of
5 subcommittees. I do think that it is an issue of
6 long-term concern for the military health system
7 as well as for the services. As an overview I'm
8 going to talk a little bit about a document that
9 was released earlier this year called "Too Fat to
10 Fight," then present a little bit of some of the
11 current and historic trends with obesity and then
12 follow-up with the questions that the Air Force
13 has put forward for the Board to consider
14 addressing in the future.

15 In April 2010, a large body of retired
16 generals and admirals as well as colonels and
17 captains from the services got together and agreed
18 to a document that was called "Too Fat to Fight."
19 It was a hark back to a call to action that
20 occurred in the 1940s and 1950s where the military
21 services had identified that there were a lot of
22 individuals who were called to service during

1 World War II who were inadequately sized thin and
2 not fat and they put forward a large effort to
3 convince Congress and the president that some kind
4 of a school lunch program was in order and they
5 used that model as a call to action for the
6 opposite problem that we are having now.

7 Important statistics that they included in their
8 document were that 75 percent of young Americans
9 between the ages of 17 and 24 were ineligible for
10 entry into the armed services or other uniformed
11 services. Of those, nearly half were ineligible
12 because of their weight. They also point out that
13 now 39 states report that 40 percent of their
14 youth are overweight or obese and that 3 report
15 that over 50 percent of their youth are overweight
16 or obese which is a staggering statistic.

17 Between 1995 and 2008, 140,000 potential
18 recruits, and these are not potential recruits who
19 were rejected by the recruiter on gross visual
20 inspection, these were ones who had passed some
21 level of visual inspection by recruiters, were
22 sent to be evaluated at the military entrance

1 processing stations and were then turned away
2 because they were too heavy. Over time between
3 that same time period the number of people who
4 were rejected based on their physicals has grown
5 over 70 percent.

6 Additionally, 1,200 individuals enter
7 basic training, go through basic training but do
8 not complete their first term of enlistment
9 because of some issue related to weight that
10 causes them to be discharged. That means in order
11 to maintain the necessary number of personnel that
12 you have to train a new person to fill that void
13 which means that we spend approximately \$60
14 million every year to replace those who do not
15 complete their first enlistment because of their
16 weight.

17 Their key recommendations were, first,
18 to remove junk food and junk drink, soft drinks
19 and sodas and so forth, out of schools. That, of
20 course, is a difficult challenge for many school
21 systems because it's net money generator. And to
22 increase funding for school lunch programs and

1 also to consider increasing funding for school
2 dinner programs for those children who clearly are
3 not likely to receive a second meal for the day
4 and to choose the types of foods that are
5 healthiest. This, of course, may reinforce better
6 eating habits if the choices that they're provided
7 are healthier. And finally, to support the
8 development, testing and deployment of proven
9 public health interventions and that may be one of
10 the questions for the Board.

11 This is data from the MSMR which is the
12 military's version of the morbidity and mortality
13 weekly report. This data comes from outpatient
14 diagnoses. The reason why I want to highlight
15 that is the scale clearly is not the true scale of
16 the problem. At this top of this line is 6
17 percent. I know from just the Air Force data for
18 the fitness program that this is probably about
19 half of what the actual figures are. The point I
20 wanted to emphasize is that if you look at the
21 blue, almost black, triangles here, they are
22 definitely on the increase over the last 5 years.

1 Then if you go for the 30- to 40-year- olds, all
2 of the services, even slightly the Marine Corps,
3 have shown an increase in the total percentage.
4 Again these are outpatient diagnoses and that
5 means that the somebody had to go to the clinic
6 and be evaluated. In some cases that's because
7 they were referred, but in other cases it may be
8 voluntary. For over 40 the climb is even higher.

9 I point out the under-20s only because
10 if you look at the last 5 years there is a steady
11 increase for the Air Force and it's the only one
12 where the Navy outdoes us. If you look at trends
13 in overweight and obesity among applicants to
14 service and this goes to some of the data that was
15 presented in "Too Fat to Fight," we've increased
16 in both the percentage who have a BMI of 25 to 30
17 from 22.8 back in 1993 to 27.1 in 2006, and for
18 those with a BMI over 30, all the way from 2.8 to
19 6.8, a 4 percent increase over about 13 years so
20 that that is a considerable change.

21 If we switch to the dependent
22 perspective if you will, and this is from the

1 "Behavioral Risk Factor Surveillance Study," which
2 is annual study performed throughout the United
3 States and includes survey items as well as some
4 data within the states themselves, and you look at
5 the scale. This is self-reported data where
6 people tell their height and tell their weight.
7 If you'll notice, there is a fair amount of no
8 data in 1985, but none of the states has more than
9 15 percent with a BMI that would be considered
10 obesity. Then if you go to 1990, you pick up a
11 lot more responses but you've also noticed that
12 the colors are beginning to increase. Then if you
13 go to 1995, and you actually have to add a new
14 category of 15 to 19 percent and over half of them
15 are now colored in the darker blue. Five years
16 later, you have to add another category which is
17 over 20 percent, and again over half of them are
18 in the new category. In 2005, you have to add not
19 just one but two more colors in order to capture
20 the data. All total you have about 4 on there
21 that are less than 20 percent. And that's 2009.

22 The questions for the Board, given the

1 trends in obesity in the U.S., how will the
2 Defense Department and the Air Force's ability to
3 recruit and retain active-duty Guard and Reserve
4 military personnel be affected? And will we need
5 to modify our accession standards in order to be
6 able to utilize the personnel who are available?
7 Perhaps we could have cyberforces who are seated
8 most of the time in dark rooms playing video games
9 and maybe they don't need to be quite as fit as
10 our Special Forces, et cetera. Assuming we don't
11 modify it, what are the best practices to attain
12 appropriate body weight for those who are
13 overweight in our active duty Guard and Reserve?
14 Assuming that some of these will fail whatever
15 methods that may be the best practices, do we
16 discharge them? Do we give them some kind of
17 waiver? What should we do with these people?

18 As for our dependents what is the
19 optimal strategy to adopt regarding both our
20 children as well as spouses and retirees? What
21 might the long-term costs be to the DOD assuming
22 these trends show no sign of decreasing? What

1 might be the best practices to address these?
2 Then we have our sons and daughters of the
3 military more likely to join the military. I
4 think we have anecdotal suggestions that this is
5 true. Ms. Bader's family might be representative.
6 If so, is there something that we should be doing
7 for those dependents to help them avoid going
8 toward the trend that's the national trend? What
9 other practices should the Defense Department
10 advocate to influence children and adolescents
11 along the lines of "Too Fat to Fight"? Thank you
12 very much.

13 DR. LEDNAR: Thank you, Colonel Gould.
14 This is obviously an issue of major national
15 importance as well as to the DOD, and for those
16 who are interested in health care and medical
17 treatment issues, you can see where this leads in
18 terms of diabetes for the future. This is a
19 major, major issue and thank you for helping us
20 get our sights up to look ahead and try to do
21 something about this at this point. Dr. Fogelman?

22 DR. FOGELMAN: I want to note one thing.

1 Thank you for that. I think that was great. In
2 the Psychological Health Subcommittee we often
3 talk about how do we asses people and when do we
4 assess them and we often raise the question of
5 what happens on accession? Are we screening them
6 adequately? What are the criteria? Everything we
7 ask about is exactly parallel to what you're
8 saying here.

9 In the last couple of days there was a
10 new story about a joint NIMH-DOD study which was
11 sparked by the issue of suicides and people who
12 were engaged in high-risk behavior and the idea of
13 what happens before accession and at accession is
14 raised there and it's been raised for quite a
15 number of issues. I'm struck at the analogy or
16 analog between the two and I wonder because of
17 that if there isn't some theme that we might as a
18 collective group want to address or think about,
19 that is, is there a way that we should offer
20 advice about accession and accession standards
21 generally and not just in the two realms we're
22 talking about? I'm raising as a discussion point.

1 DR. LEDNAR: To build on what Dr.
2 Fogelman said, our traditional medical
3 armamentarium is diagnose and doctor treat.
4 Colonel Gould, what you've raised up is this is
5 about choice. This is about the individual making
6 a choice and this is not a choice in a medical
7 clinic office. I think our skill set to help
8 persuade people, enlighten them, support them in
9 their decisions outside of the whole medical
10 treatment system, we've got to get a whole lot
11 better and we'll probably need to engage some
12 skills that are not traditional medical skills.
13 Some of the areas that Dr. Fogelman and his
14 subcommittee has expertise in I think we need to
15 better engage and deploy. This is not coming up
16 with a new positron. This is a whole different
17 issue. Dr. Parkinson and Dr. Kaplan?

18 DR. PARKINSON: Phil, thank you very
19 much for that. I think the Board goes back and
20 forth between the macro and the micro and the
21 macro and the micro and I think you've nailed the
22 macro issue for affordability and sustainability

1 of not just health care, but the employed sector
2 of this economy. I was sitting next to an HR
3 director for a Fortune 500 company, she herself
4 was based in Fresno and point blank said, "We have
5 good, high-paying manufacturing jobs available
6 today. Ninety percent of the applicants coming in
7 our door cannot physically meet the requirements
8 to do them and that's before the drug screen. I
9 essentially can't hire anybody in the United
10 States." I won't name the name of this company,
11 but that's why they're outsourcing jobs. In many
12 ways if there's anything that the DHB does going
13 back to what Eisenhower sometimes said about using
14 the military to essentially bring race relations
15 into the 21st century, I think there is a role as
16 Dr. Taylor and the department talks about and
17 whatever next generation TRICARE is, he made it
18 quite clear in his opening comments with the
19 cameras off, frankly, that it's not about the
20 contracts, it's about rethinking the contract
21 about what are we doing for our people and how do
22 we make it affordable and healthier.

1 I'll leave the group with another
2 thought. Phil, you hit the nail on the head. The
3 Robert Wood Johnson Foundation had a Building
4 Healthy Communities Commission that did a report
5 now about a year ago. The punch line is this,
6 where and how we live, learn, work and play, those
7 four areas, are bigger determinants of our health,
8 longevity and our health care than medical care.
9 A world- class medical facility notwithstanding,
10 it is largely peripheral to what we're talking
11 about. And when it gets to the point where we're
12 actually talking about backing off on health
13 standards, I love the fact that you asked the
14 provocative question.

15 I wrote down CPA. With cyberforces of
16 the future, CPA is going to stand for couch potato
17 ace. Heaven forbid if we the military, and I love
18 it because you're asking this question, should we
19 back off on health standards because frankly we
20 just can't do it and frankly we got to give up?

21 This week, at the other end of the
22 spectrum in the New England Journal in a

1 randomized controlled trial, 40-plus BMI
2 individuals who were given intensive lifestyle and
3 behavioral changes, guess what? They all lost 10
4 percent plus of weight so that they're not going
5 to bariatric surgery. Who better at both ends of
6 the spectrum gets serious about this than the
7 Department of Defense? I think the DHB through
8 all of the tentacles that we have, from Dr.
9 Taylor's charge, to Secretary Gates saying get
10 this thing under control and now we can't recruit
11 the people we need for the active-duty military?
12 We've got a perfect storm and I think there's a
13 lot we can contribute maybe not answering these
14 questions per se but they put us on the path to do
15 that in concert with the department.

16 DR. LEDNAR: Dr. Kaplan, Dr. O'Leary and
17 then Dr. Poland.

18 DR. KAPLAN: I was sitting here looking
19 at the graph, Phil.

20 LIEUTENANT COLONEL GOULD: Which graph,
21 sir?

22 DR. KAPLAN: I'm sorry.

1 LIEUTENANT COLONEL GOULD: Do you have a
2 slide number? The bottom right-hand corner.

3 DR. KAPLAN: The first graph, the 20- to
4 30-year- old obesity trends. There are two things
5 that struck me and maybe they're totally wrong.
6 There is no question about the increase in
7 obesity. The first question is it's interesting
8 if you look at this graph that the Marines are
9 down at the bottom and show the least slope up.
10 Is that because of preselection or is that because
11 they are more active?

12 LIEUTENANT COLONEL GOULD: That's a
13 great question. The interesting thing is of all
14 the services, they have the most lenient entry
15 requirements and yet they are able through their
16 aggressive training as well as ongoing
17 requirements to maintain their body weight. The
18 answer is they're not the most stringent, in fact
19 they're the least stringent of the services in
20 their entry requirements, but they whip them into
21 shape. At MCRD San Diego they'll tell you that
22 the average diet of the Marines during training is

1 6,000 calories per day.

2 GENERAL MYERS: To follow-up on that,
3 Phil, the thing that might skew that data is that
4 75 percent of Marines are on their first
5 enlistment and I think that number still holds.
6 They bring them in young probably under 20 and by
7 22 or 23 they're out. I don't know how that
8 influences that data, but it's different than the
9 Army model, the Navy model or the Air Force.

10 DR. SHAMOO: I have an informational
11 question on the same graph just to attain further
12 clarification.

13 DR. LEDNAR: Let's have Dr. Kaplan get
14 to question two, then we'll have Dr. Shamoo, Dr.
15 O'Leary and Dr. Poland.

16 DR. KAPLAN: The second question I have
17 is in a way related to what General Myers just
18 said. I was trying to figure this out and I don't
19 know it. During this period of time, from 1998 to
20 2008, if I remember back there were periods of
21 time in there where several of the services had
22 trouble meeting recruitment expectations. Can one

1 speculate that maybe the qualifications changed in
2 order to meet the recruitment expectations and
3 that one ends up with a different breed of cat as
4 an enlistee at that point?

5 LIEUTENANT COLONEL GOULD: I'm going to
6 have to defer to AMSARA for that.

7 DR. LEDNAR: Dr. Shamoo?

8 DR. KAPLAN: AMSARA is the Accession
9 Medical Standards Analysis and Research Activity
10 for the record.

11 DR. LEDNAR: Dr. Shamoo?

12 DR. SHAMOO: You have here percent of
13 service members with clinical diagnoses of
14 overweight.

15 LIEUTENANT COLONEL GOULD: Yes. Those
16 are outpatient diagnoses, sir.

17 DR. SHAMOO: These are self-referred?
18 This is not a survey?

19 LIEUTENANT COLONEL GOULD: No, it is not
20 a survey. It's not a perfect data point. I fully
21 admit that.

22 DR. SHAMOO: That's what I'm saying.

1 LIEUTENANT COLONEL GOULD: Absolutely,
2 sir.

3 DR. SHAMOO: That's very important.
4 This data could be totally different because this
5 is people who have been diagnosed when? How did
6 they end up seeing a doctor about their obesity?
7 This is not a survey so that I question the whole
8 integrity of this data in terms of its accuracy
9 reflecting through measure of obesity within the
10 services.

11 LIEUTENANT COLONEL GOULD: I know that
12 it's not accurate, but my point is I do think that
13 the trend is probably close to the truth whether
14 the actual number is not. I know for the 20 to
15 30s that it's half of what the actual data shows
16 for the Air Force in terms of their fitness
17 profiles. Recognizing that it's not a perfect
18 data measure doesn't necessarily alter that.

19 DR. LEDNAR: I think Colonel Gould has
20 tried to make clear to us the source of the data
21 and what its limitations are. Directionally, this
22 and other data point to the fact that we have a

1 real issue however we want to count the numbers
2 and describe it. It doesn't take any energy out
3 of the importance of this issue I believe. Dr.
4 O'Leary?

5 DR. O'LEARY: I totally agree. I want
6 to pick up on Mike Parkinson's point. This is
7 bigger than the military and it is bigger than
8 TRICARE. This is a national readiness issue, it's
9 a public health issue and we seem not to have been
10 able to capture the attention of the American
11 public by saying this is a health issue that's
12 going to drive up health care costs, diabetes, et
13 cetera. I think if you start talking about
14 describing the broader impacts of obesity and the
15 role that the military could play in driving this
16 issue and unpopular things like restricting soda
17 pop access and pushing family counseling and doing
18 things that we know that work even though people
19 may see this as some sort of Big Brother
20 intervention, this is becoming a national risk
21 issue and I think it is a leadership opportunity
22 for the military.

1 DR. LEDNAR: Dr. Poland?

2 DR. POLAND: I agree with those
3 sentiments. Also Charlie said this is very much a
4 cross-cutting issue for the way we are currently
5 organized as a Board and we'll have to think
6 through how to address it.

7 I have a couple of thoughts. I would as
8 you did distinguish between overweight and obese.
9 The second point is that there are beginning to be
10 reasonably evidence-based interventions that work.
11 The third point is I think it deserves a lot of
12 thought as to whether accession standards should
13 be changed. For example, your example with the
14 cyberforces.

15 In the case of obesity and not
16 overweight, you begin to get into issues of
17 presentism as well as a lot of issues related to
18 follow-on medical problems. A closely aligned
19 problem with that is sleep apnea for example.
20 Depending on what you mean by cyberforces, I want
21 that person awake, alert, et cetera. But the
22 evidence is just barely beginning to accumulated

1 about decreased effectiveness of the obese, not
2 the overweight but the obese, in the workforce.
3 So there are a lot of issues that attend this and
4 I commend you for raising it as an important
5 issue.

6 DR. LEDNAR: Dr. Fogelman?

7 DR. FOGELMAN: Thinking about Mike's
8 point I have a question which may be a policy
9 question that's probably larger than the Board but
10 since it's an issues which is always on my mind,
11 thinking about the integration of the services and
12 how that affected the country as a whole and
13 several other things along the way, didn't all of
14 those occur when there was a draft? That's my
15 whole question.

16 DR. LEDNAR: We won't look for an answer
17 at the moment to that question. I would like
18 however to wrap up this discussion with a
19 suggestion, Colonel Gould. Offline if you'd have
20 a conversation with Ms. Bader, she can offer some
21 advice on the way ahead. How do we take this
22 issue? How do we work with it? How do we bring

1 it to the Board and get some forward motion going
2 staying very cognizant of what Dr. Poland said
3 that this is a very, very broad cross- cutting
4 issue that's got more than health components and
5 we want to thoughtful about how we go about this.
6 So if you would have a conversation with Ms.
7 Bader, she can advise on how to go ahead. Thank
8 you for brining this issue and than you for
9 preparing this brief to us. Thank you.

10 Our next brief will be given by
11 Lieutenant Commander Brett-Major. Lieutenant
12 Commander Major is a prior surface warfare officer
13 now working in Navy medicine. As an internal
14 medicine and infectious disease physician, his key
15 areas of specialization are in tropical public
16 health and blood-borne pathogens. He currently
17 serves as program director for U.S. Military
18 Tropical Medicine, a tri-service program led by
19 Navy medicine, which educates and trains U.S.
20 military physicians in the practice of medicine in
21 developing areas. In addition, he is also acting
22 head of the Navy's Central HIV Program and an

1 officer of the Armed Forces Infectious Disease
2 Society. Should I have said Captain Naito?

3 CAPTAIN NAITO: I was going to introduce
4 Lieutenant Commander Brett-Major.

5 DR. LEDNAR: Thank you. Captain Naito,
6 please introduce.

7 CAPTAIN NAITO: The reason why I asked
8 him to speak is in regard to giving you an update
9 on HIV epidemiology in the Navy and given the
10 topical interest at the Pentagon for certain
11 issues, I thought it would be good for him to give
12 you an update that he gave to our senior
13 leadership in this regard.

14 LIEUTENANT COMMANDER BRETT-MAJOR: Thank
15 you, Captain. Distinguished Board members, ladies
16 and gentlemen, good afternoon. And thank you for
17 this opportunity for me to brief our program to
18 you and also to tell you about some of our recent
19 activities. This is an informational brief.

20 The Navy's Central HIV Program is a
21 Bureau of Medicine and Surgery activity that on
22 October 1 administratively realigned under the

1 Navy-Marine Corps Public Health Center. We act as
2 the Bureau of Medicine and Surgery's coordinating
3 agent for Navy medicine's responsibility under our
4 Secretary of the Navy Instruction which governs
5 the way the Department of the Navy approaches HIV
6 infection, screening, prevention, tracking,
7 personnel management and so on. Fundamentally our
8 job is to promote HIV-related force health
9 protection and readiness.

10 You know Captain Naito already. He is
11 our program's mentor at the Bureau of Medicine and
12 Surgery and he's the gentleman who has to answer
13 the telephone for all of my misdeeds. Also in the
14 back, Dr. Scott, if you would stand up just for a
15 moment, sir. He is the department head for
16 epidemiology and threat assessment in the
17 military's HIV Research Program which is an Army
18 Executive Agency run out of the Division of
19 Retrovirology, and why he is here will become
20 apparent in a moment.

21 You may already be familiar with the
22 state of HIV infection throughout the United

1 States. This is 2007 data from the Centers for
2 Disease Control. I'm a Floridian, so I pick on
3 Florida a lot, but generally in high-population
4 areas in Florida in particular the rate is about 1
5 to 3 per 1,000 just to give you some context for
6 the Navy-Marine Corps numbers I'm going to show
7 you in a moment.

8 Another thing to notice is while this is
9 AIDS and not HIV data, it does demonstrate density
10 of disease around the United States and you can
11 see in these high-population areas of regions of
12 HIV intensity with bad clinical HIV. These are
13 all areas where we heavily recruit and enlist,
14 these are areas where we train our people both in
15 intake and pipeline training and in a couple of
16 particular areas they're areas where we have them
17 operationally assigned.

18 The global HIV burden can be a bit more
19 challenging to describe. Certainly there are
20 regions that do not report robustly their HIV
21 burden within their populace but you can
22 appreciate quickly that areas of frequent

1 deployment of Department of the Navy personnel are
2 areas with high transmission with the darker
3 colors. Translating these potential domestic and
4 global exposures can be challenging. However, the
5 Navy's Central HIV Program screens the entire
6 Navy-Marine Corps for the seroprevalence of HIV.

7 We evaluate every service member by DOD
8 policy every 2 years. But in actuality we screen
9 approximately 70 percent of the force each year
10 and that's a consequence of peri-deployment
11 requirements for theater entry for our service
12 members. This is HIV incidence per 1,000 active-
13 duty-tested sailors and Marines and our incidence
14 is about 1 out of 3,000 for the Navy and about 1
15 out of 1,500 for the Marine Corps, so that these
16 are individuals not known to be HIV positive who
17 were evaluated by routine or other referred
18 screening.

19 Prevalence is a little bit higher are
20 you might expect with accumulation of service
21 members. We routinely keep HIV-infected service
22 members in the Navy and Marine Corps functioning.

1 Our results clinically with our service members
2 and their return to duty are very good. But we
3 have about 1 out of 1,000 sailors as HIV positive
4 and 1 out of every 2,000 Marines as HIV positive.
5 Like the force structure, the HIV population in
6 the Navy and Marine Corps is predominantly
7 overwhelmingly men. Among 2009 incidence of HIV
8 infections which are almost completely among the
9 enlisted ranks, we have a small smattering of
10 officers who are infected each year, but the
11 overwhelming number are among enlisted personnel,
12 like the civilian pandemic of HIV in the
13 communities which are troops encounter, it is
14 predominantly among African Americans and
15 Hispanics although certainly the rates among
16 Caucasians is not trivial.

17 If you tried to translate our numbers
18 into a unit and were to presume for a moment that
19 there were gaps or if you were to try and
20 transcribe those numbers into a unit size and get
21 a sense for organizational population of HIV, this
22 wouldn't actually be true, of course. Because we

1 reassign as policy in the Department of the Navy
2 service members HIV positive into units where
3 they're not deployed overseas about six to 10 out
4 of a Marine division. The entire way that the
5 Navy's Central HIV Program and I think indeed our
6 counterpart activities in the Army and the Air
7 Force are designed around an initial concern in
8 the 1990s for stigma and protection of privacy
9 which I think was an understandable construct.

10 But over the last year and a half or so
11 we started getting some very reasonable questions.
12 Our Navy Personnel Command started asking me in
13 late 2009 about what they perceive of clusters of
14 transmission in a couple of centers where
15 individuals are trained. When I drilled down into
16 their personnel data to see if that had
17 credibility I wasn't able to validate their
18 concern, but the question that sponsored their
19 interest in us was very reasonable: There is the
20 potential change in DOD policy.

21 Also Navy medicine got some good press
22 down in the Tidewater area for the way that HIV

1 patients were being managed by one of our HIV
2 Evaluation and Treatment Units at Navy Medical
3 Center Portsmouth and then some very reasonable
4 questions followed about the nature of infection
5 in the population which we've retained with HIV
6 following that. Theater commands are always
7 struggling with the difficulties in timing various
8 disease screening programs in order to limit
9 deployment of those diseases in their areas of
10 operation and dealing with those issues of timing
11 and screening.

12 Everyone was asking what you might
13 expect we ask ourselves all of the time which is
14 who is getting infected, where is it happening,
15 when is it happening, how is it happening and why
16 is it happening. Our stakeholders range from
17 personnel commands in the Navy and Marine Corps to
18 the various medical entities that are responsible
19 for providing a fit and ready force to our line
20 stakeholders. Certainly the potential policy
21 change for personal behavior is relevant. In the
22 United States the epidemic while every group is

1 touched, it's predominantly a group of young men
2 who have sex with men.

3 There is also the issue of whether or
4 not the tests which we routinely employ in order
5 to detect HIV when we think about firewalls and
6 barriers of bringing HIV people in and detecting
7 them early before we put HIV- infected service
8 members in areas where we do not want them whether
9 the fidelity is high enough to do what we want
10 those tests to do, and there are limitations
11 certainly with our screening tests.

12 This figure here shows the progression
13 of detectable elements as a consequence of
14 infection in someone's blood when they've been
15 infected by HIV, and on the far left is RNA
16 proceeding toward the early immunologic markers to
17 the later immunologic markers and early on with
18 testing with first- and second-generation
19 enzyme-linked immunosorbent assays, typically
20 someone had to be infected for 6 to 12 weeks
21 before you'd detect it.

22 Interestingly, we had not switched to

1 more modern ELISAs until relatively recently and
2 the third-generation ELISA which now starts to
3 include antigenic epitopes that are recombined and
4 put on the card for detection for higher
5 detectability can detect within about a month, and
6 recently the FDA approved a fourth-generation
7 assay for the purpose of blood donation screening
8 which employs also some antigens, some little bits
9 of the virus itself rather than the immune
10 response which shortens that to about 3 weeks and
11 possibly down to 2 weeks, and then you have
12 nucleic acid testing which is pretty good from 7
13 to 2 weeks, but those are normal distribution
14 curves of response and so the window can be
15 variable depending on your population and where
16 and how those assays are performed.

17 The observation in preparation for
18 thinking about a change in accession policy
19 regarding Don't Ask, Don't Tell was that there
20 really was insufficient evidence to say much about
21 what would happen to the HIV burden and that this
22 was an area that deserved monitoring. The last

1 substantive effort to have a close look at how HIV
2 transmission toward our service members including
3 their behavioral risk factors was published by
4 Stephanie Brodine and her group out of Navy
5 Medical Center San Diego as a part of the
6 Department of Defense's Natural History Study now
7 known as RV-168. It was a good study though it
8 was restricted to research-inducted population
9 west of the Mississippi.

10 The Army has recent experience which we
11 benefited much from where they explored with Army
12 leadership, the Army Public Health Command and the
13 Military HIV Research Program, a little bit about
14 HIV transmission dynamics associated with their
15 force and those were informative for us for what
16 I'm about to describe for you. The Navy's Central
17 HIV Program with Captain Naito approached the
18 Military HIV Research Program and we said we now
19 want to start asking these questions in a
20 systematic way that will inform we look
21 prospectively at new individuals who are
22 identified as HIV positive and also we can inform

1 our educational practices across our service and
2 potentially provide operational and actionable
3 public health intelligence. This is a quality
4 assurance fundamentally activity for our program
5 which as public health responsibilities under the
6 Secretary of the Navy Instruction and it's
7 descriptive epidemiology with potential
8 exploratory analyses dependent on cluster
9 identification.

10 We were trying to describe the timing,
11 geography, mode and risks of contemporary
12 seroincident HIV infections in the Navy and Marine
13 Corps. We want to as we are able interrupt
14 ongoing transmission networks. We want to
15 optimize our strategies for detecting HIV in the
16 force. We want to enhance our educational
17 programs. The Navy and Marine Corps Public Health
18 Center executes a program called the Sexual Health
19 and Responsibility Program. We want to improve
20 our understanding of the high-risk groups in order
21 to target our interventions both screening and
22 education appropriately. And we want to inform

1 our future decisions for how we handle screening
2 as our population evolves.

3 We took a lot of lessons from the Army
4 and we're trying to merge personnel health,
5 diagnostic testing and molecular epidemiologic
6 data in order to produce a geospatial temporal
7 map. Our own data coupled with the Navy and
8 Marine Corps Public Health Center, the Department
9 of Defense Serum Repository with the Armed Forces
10 Health Surveillance Center, the Military HIV
11 Research Program, our personnel entities,
12 Personnel Command Headquarters Marine Corps and
13 the sailors and Marines themselves will all
14 contribute to the construct of this map.

15 In the winter and spring of 2010, we
16 organized our effort. We sought peer review
17 through the Military Infectious Diseases Research
18 Program and received a favorable rating. Then
19 especially since we had a research element
20 supporting our technical efforts went to the
21 Walter Reed Army Institute of Research IRB to
22 review our strategy and ensure that we were

1 operating within our role as a public health and
2 quality assurance activity and we received a
3 nonresearch determination from the WRAIR IRB. We
4 approached our stakeholders, first the Navy
5 Personnel Command and achieved personnel data
6 pools from which we'll start our map of where
7 people were over the course of their careers and
8 compare that to serovalidated time windows of
9 likely infection. Then we were also very
10 fortunate in that we received a seed money grant
11 award from MIDRIT that allowed us to get going.
12 MHRP has unique skills in terms of firewalls
13 between operational activities and research and
14 privacy with that information both with their work
15 with the Natural History Study and their recent
16 activities with the Army and their EpiCON and
17 we're utilizing that as they're building secure
18 databases and data structure for us and we're
19 beginning our laboratory exploration.

20 We finally have our last negative
21 samples starting to get organized and we're going
22 to begin testing and verifying our dates for our

1 infection window. Headquarters Marine Corps is
2 pulling some data for us and we're progressing.
3 Our collaborators across our communities and
4 stakeholders have been extremely supportive and we
5 have sufficient money to get our data structures
6 together to begin analyzing held data and to begin
7 validating the window of infection. The molecular
8 epidemiology in such a project is quite expensive
9 and we do not yet have that funding.

10 As we collect data and we are
11 comfortable with its validity and relevance to
12 stakeholders, we plan to brief them in an interim
13 fashion. We're hopeful that our effort will also
14 help inform through our process and through the
15 Army's process also with HIV recently a force-
16 wide HPV-HCV study which is on the horizon in the
17 general rubric of blood-borne pathogens. We're
18 also hopeful that our data collection in this
19 fashion will help us in our current dialogue
20 initiated this fall most robustly to start sharing
21 roles and responsibilities to at least understand
22 how our various service-specific HIV program

1 elements align and how we can support each other.

2 Thank you very much. Questions?

3 DR. LEDNAR: Thank you, Lieutenant
4 Commander Brett-Major. Are there questions for
5 Lieutenant Commander Brett-Major? Dr. Silva?

6 DR. SILVA: It looks like a study and
7 hopefully we'll learn a lot. The acronym MHRP,
8 what is that?

9 LIEUTENANT COMMANDER BRETT-MAJOR: Yes,
10 sir. That's the Military HIV Research Program.
11 It's the DOD title for Walter Reed's Division of
12 Retrovirology.

13 DR. LEDNAR: Are there other comments?
14 Commander Brett-Major, thank you for this brief
15 and to Captain Naito for bringing this brief to
16 the Board and to each of our service liaisons,
17 thank you for your considered thought about what
18 topics to bring and for preparing these briefs. I
19 think a number of us have been feeling this has
20 been a very good decision by the Board to restart
21 again this practice of regular briefs from the
22 services, so I thank you for making this a very

1 successful session of the Defense Health Board.

2 As we move toward adjournment, I'll make
3 a reflection before I turn the microphone over to
4 Ms. Bader. When we think about the topics that
5 we've talked about in the last 2 days, several
6 words come to my mind: Priority, timeliness,
7 urgency, relevance, and I think this is central to
8 what the Defense Health Board can do with and for
9 the Department of Defense. Again, we are able to
10 best provide independent advice to the Department
11 of Defense to the extent that we have good briefs
12 that are coming on important topics to the Board.

13 I think I'll also reflect on the fact
14 that efforts by Defense Health Board staff -- and
15 I'm looking at Marianne Coates and the work that
16 she's done -- in interacting with media to have
17 them understand more about the Board and in fact
18 to find a way to have success as we've seen with
19 the recent Washington Post physician reporter and
20 again with Dr. Butler's assistance and others have
21 really provided some insight to the readership of
22 The Washington Post which is broad about the

1 objective reality of our forces. And that
2 wouldn't have happened if Marianne hadn't made
3 that connection, if Frank Butler hadn't found a
4 way to navigate through the realities of
5 supporting a reporter to get embedded into a
6 military unit to write a report that really
7 describes the reality. This is really a team
8 effort and a lot of success, Marianne, thanks to
9 you and to Frank.

10 On that note, I would ask if Ms. Bader
11 as our Designated Federal Official would share any
12 administrative comments and then to officially
13 bring our meeting to adjournment. Ms. Bader?

14 MS. BADER: Some good news: I don't
15 have any administrative comments to make so I'm
16 sure everybody is happy about that. Yes, applause
17 all the way around. I'd like to thank everybody
18 for their attendance today and of course for their
19 tremendous support of the Defense Health Board,
20 and with that I call this meeting adjourned.
21 Thank you.

22 DR. LEDNAR: A reminder. If you haven't

1 already signed in today, including myself, please
2 be sure to stop at the front desk sometime.

3 (Whereupon, the PROCEEDINGS were
4 adjourned.)

5 * * * * *

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

1 CERTIFICATE OF NOTARY PUBLIC

2 DISTRICT OF COLUMBIA

3 I, Christine Allen, notary public in and
4 for the District of Columbia, do hereby certify
5 that the forgoing PROCEEDING was duly recorded and
6 thereafter reduced to print under my direction;
7 that the witnesses were sworn to tell the truth
8 under penalty of perjury; that said transcript is a
9 true record of the testimony given by witnesses;
10 that I am neither counsel for, related to, nor
11 employed by any of the parties to the action in
12 which this proceeding was called; and, furthermore,
13 that I am not a relative or employee of any
14 attorney or counsel employed by the parties hereto,
15 nor financially or otherwise interested in the
16 outcome of this action.

17
18
19 -----

20 Notary Public, in and for the District of Columbia

21 My Commission Expires: January 14, 2013
22